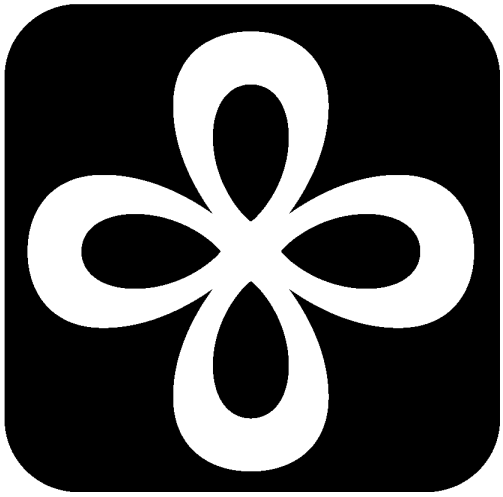
STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES

MEDICAID



Provider Manual

Nursing Facility

CHAPTER E. COVERAGE AND LIMITATIONS

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APPENDIX

This chapter outlines the policies and procedures governing nursing facility care, one of the health care services available in Iowa through the Medicaid program. The chapter covers all nursing facilities, whether free-standing nursing homes, distinct parts of hospitals, or nursing facilities that are Medicare-certified.

Nursing facilities wishing to participate in the Medicaid program must comply with federal and state rules and regulations. This chapter sets forth the standards and requirements that are conditions for participation in the Medicaid program.

I. CERTIFICATION PROCEDURES

All nursing facilities must enter into a contractual agreement with the Department that sets forth the terms under which they will participate in the Medicaid program. The steps leading to certification of a nursing facility and issuance of a Medicaid provider agreement are:

- The facility obtains the applicable license from the Health Facilities Division of the Iowa Department of Inspections and Appeals (DIA).
- The facility requests Medicaid application materials from the Medicaid fiscal agent, completes the application, and returns it to the fiscal agent.
- The DIA Division of Health Facilities, under contract to the Department of Human Services, surveys the facility for compliance with Medicaid certification standards.
- DIA recommends the facility for certification as a nursing facility.
- The Department of Human Services issues a provider agreement.

The Department office responsible for the nursing facility portion of the program is the Bureau of Health Care Purchasing and Quality Management in the Division of Medical Services.

Facilities may order DHS forms and brochures from the Iowa State Industries. Facilities may obtain a *Form Order Blank* by calling 1-800-432-9163. The address of the Iowa State Industries is Anamosa, Iowa 52205.

The following sections give additional information on:

- Certification surveys.
- Provider agreements.

A. Certification Survey

All survey procedures must be in accordance with U.S. Department of Health and Human Services publication "Providers Certification State Operations Manual."

New facilities must contact DIA initially. The Health Facilities Division schedules and completes an unannounced survey of the facility, in cooperation with the State Fire Marshal. After the initial survey, DIA schedules the survey.

Form HCFA-671, *Long Term Care Facility Application for Medicare and Medicaid*, collects information regarding the services the facility intends to provide. A facsimile of this form follows. Facilities must complete this form:

- At the initial request for Medicaid certification.
- Upon each survey of the facility.

Both the Health Facilities Division and the State Fire Marshal use form HCFA-2567L, *Statement of Deficiencies and Plan of Correction*, to notify the facility of any deficiencies and ask for a plan for their correction.

The Health Facilities Division evaluates the survey findings and plan of correction and decides whether to recommend the facility for certification as a Medicaid facility.

If the facility is recommended for Medicaid certification, the Department of Inspections and Appeals notifies the Department of Human Services and makes recommendations about terms and conditions of a provider agreement.

The following sections cover:

- Plans of correction when a facility is found to be out of compliance.
- Facsimiles of the application and statement of deficiencies.

1. Plan of Correction

The facility must submit a plan of correction to the Iowa Department of Inspections and Appeals within 15 calendar days from the date DIA mails the survey results to the provider. (If more time is required, the facility may request an extension from DIA.) DIA must approve this plan before the facility can be recommended for certification in the Medicaid program.

If the survey indicates deficiencies in the areas of American National Standards Institute (ANSI) standards, or environment, the facility must submit a timetable detailing corrective measures. This timetable must detail corrective steps to be taken and when corrections will be accomplished. Time allowed will depend upon the deficiency cited.

The following standards apply in these instances:

- The Department of Inspections and Appeals must approve the timetable submitted in the plan of correction.
- During the period allowed for corrections, the facility must be in compliance with existing state fire safety and sanitation codes.
- DIA must survey the facility at least semiannually until corrections are completed.
- The facility must have made substantial effort and progress in its plan of correction as evidenced by work orders, contracts, etc. Continued verification is contingent upon no period of substantial compliance beyond six months.

If the survey indicates deficiencies in the life safety code, the facility must also submit a timetable detailing corrective measures. The State Fire Marshall must review and approve the plan for corrective measures. The State Fire Marshall must recommend approval or denial of life safety code waivers.

The federal Health Care Financing Administration has the final decision on life safety code waivers and any timetables submitted for correction.

2. Facsimile of HCFA-671

See the following pages for instructions for completing form HCFA-671, *Long Term Care Facility Application for Medicare and Medicaid*, and a sample of the form.

3. Facsimile of HCFA-2567L

See the following pages for a sample of form HCFA-2567L, *Statement of Deficiencies and Plan of Correction*.

GENERAL INSTRUCTIONS AND DEFINITIONS
(use with HCFA-671 Long Term Care Facility Application for Medicare and Medicaid)
GENERAL INSTRUCTIONS

THIS FORM IS TO BE COMPLETED BY THE FACILITY

Standard Survey - LEAVE BLANK - Survey team will complete
Extended Survey - LEAVE BLANK - Survey team will complete

INSTRUCTIONS AND DEFINITIONS

Name of Facility - Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number - Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address - Street name and number refers to physical location, not mailing address, if two addresses differ.

City - Rural addresses should include the city of the nearest post office.

County - County refers to parish name in Louisiana and township name where appropriate in the New England States.

State - For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code - Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number - Include the area code.

State/County Code - LEAVE BLANK - State Survey Office will complete.

State/Region Code - LEAVE BLANK - State Survey Office will complete.

Block F9 - Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10 - If the facility is under administrative control of a hospital, check "yes", otherwise check "no".

Block F11 - The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12 - Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block.)

Definitions to determine ownership are:

FOR PROFIT - If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

NONPROFIT - If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

GOVERNMENT - If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13 - Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no". A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14 - If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15-F23 - Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24 - Check "yes" if the facility currently has an organized residents group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no".

Block F25 - Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no".

Block F26 - Check “yes” if the facility conducts experimental research; otherwise check “no”. Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27 - Check “yes” if the facility is part of a continuing care retirement community (CCRC); otherwise check “no”. A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28-F31 - If the facility has been granted a nurse staffing waiver by HCFA or the State Agency in accordance with the provisions at 42CFR 483.30(c) or (d), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32 - Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no".

FACILITY STAFFING

GENERAL INSTRUCTIONS

This form requires you to identify whether certain services are provided and to specify the number of hours worked providing those services. Column A requires you to enter “yes” or “no” about whether the services are provided onsite to residents, onsite to nonresidents, and offsite to residents. Columns B-D requires you to enter the specific number of hours worked providing the service. To complete this section, base your calculations on the staff hours worked in the most recent complete pay period. If the pay period is more than 2 weeks, use the last 14 days. For example, if this survey begins on a Tuesday, staff hours are counted for the previous complete pay period.

Definition of Hours Worked - Hours are reported rounded to the nearest whole hour. Do not count hours paid for any type of leave or non-work related absence from the facility. If the service is provided, but has not been provided in the 2-week pay period, check the service in Column A, but leave B, C, or D blank. If an individual provides service in more than one capacity, separate out the hours in each service performed. For example, if a staff person has worked a total of 80 hours in the pay period but has worked as an activity aide and as a Certified Nurse Aide, separately count the hours worked as a CNA and hours worked as an activity aide to reflect but not to exceed the total hours worked within the pay period.

Completion of Form

Column A - Services Provided - Enter Y (yes), N (no) under each sub-column. For areas that are blocked out, do not provide the information.

Column A-1 - Refers to those services provided onsite to residents, either by employees or contractors.

Column A-2 - Refers to those services provided onsite to non-residents.

Column A-3 - Refers to those services provided to residents offsite/or not routinely provided onsite.

Column B - Full-time staff, C - Part-time staff, and D - Contract - Record hours worked for each field of full-time staff, part-time staff, and contract staff (do not include meal breaks of a half an hour or more). Full-time is defined as 35 or more hours worked per week. Part-time is anything less than 35 hours per week. Contract includes individuals under contract (e.g., a physical therapist) as well as organizations under contract (e.g., an agency to provide nurses). If an organization is under contract, calculate hours worked for the individuals provided. Lines blocked out (e.g., Physician services, Clinical labs) do not have hours worked recorded.

REMINDER - Use a 2-week period to calculate hours worked.

DEFINITION OF SERVICES

Administration - The administrative staff responsible for facility management such as the administrator, assistant administrator, unit managers and other staff in the individual departments, such as: Health Information Specialists (RRA/ARTI), clerical, etc., who do not perform services described below. Do not include the food service supervisor, housekeeping services supervisor, or facility engineer.

Physician Services - Any service performed by a physician at the facility, except services performed by a resident’s personal physician.

Medical Director - A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility.

Other Physician - A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.

Physician Extender - A nurse practitioner, clinical nurse specialist, or physician assistant who performs physician delegated services.

Nursing Services - Coordination, implementation, monitoring and management of resident care plans. Includes provision of personal care services, monitoring resident responsiveness to environment, range-of-motion exercises, application of sterile dressings, skin care, naso-gastric tubes, intravenous fluids, catheterization, administration of medications, etc.

Director of Nursing - Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.

Nurses with Administrative Duties - Nurses (RN, LPN, LVN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service, or other duties which are not considered to be direct care giving. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

Registered Nurses - Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.

Licensed Practical/Vocational Nurses - Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.

Certified Nurse Aides - Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150(a) and (3) and who are providing nursing or nursing-related services to residents. Do not include volunteers.

Nurse Aides in Training - Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.

Medication Aides/Technicians - Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.

Pharmacists - The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.

Dietary Services - All activities related to the provision of a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Dietitian - A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

Food Service Workers - Persons (excluding the dietitian) who carry out the functions of the dietary service (e.g., prepare and cook food, serve food, wash dishes). Includes the food services supervisor.

Therapeutic Services - Services, other than medical and nursing, provided by professionals or their assistants, to enhance the residents' functional abilities and/or quality of life.

Occupational Therapists - Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.

Occupational Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Occupational Therapist (OT) to carryout the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50% of their time as Activities Therapists.

Occupational Therapy Aides - Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Physical Therapists - Persons licensed/registered as physical therapists, according to State law where the facility is located.

Physical Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.

Physical Therapy Aides - Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Speech-Language Pathologists - Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).

Therapeutic Recreation Specialist - Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.

Qualified Activities Professional - Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) or 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed above.

Other Activities Staff - Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.

Qualified Social Worker(s) - Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly individuals.

Other Social Services Staff - Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.

Dentists - Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.

Podiatrists - Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

Mental Health Services - Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to:

- Diagnose, describe, or evaluate a resident's mental or emotional status;
- Prevent deviations from mental or emotional well-being from developing; or
- Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function.

Among the specific services included are psychotherapy and counseling, and administration and monitoring of psychotropic medications targeted to a psychiatric diagnosis.

Vocational Services - Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.

Clinical Laboratory Services - Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.

Diagnostic X-ray Services - Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.

Administration and Storage of Blood Services - Blood bank and transfusion services.

Housekeeping Services - Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping services supervisor and facility engineer.

Other - Record total hours worked for all personnel not already recorded, (e.g., if a librarian works 10 hours and a laundry worker works 10 hours, record 00020 in Column C).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From F1 ☐☐ ☐☐ ☐☐ (M M D D Y Y) To F2 ☐☐ ☐☐ ☐☐ (M M D D Y Y)

Extended Survey
From F3 ☐☐ ☐☐ ☐☐ (M M D D Y Y) To F4 ☐☐ ☐☐ ☐☐ (M M D D Y Y)

Name of Facility	Provider Number	Fiscal Year ending: F5 ☐☐ ☐☐ ☐☐ (M M D D Y Y)

Street Address	City	County	State	Zip Code

Telephone Number: F6	State/County Code: F7	State/Region Code: F8

A. F9 ☐☐
01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☐

If yes, indicate Hospital Provider Number F11 ☐☐☐☐☐☐☐

Ownership F12 ☐☐

For Profit	**NonProfit**	**Government**	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization F 13 Yes ☐ No ☐

Name of Multi-Facility Organization F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children / Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator / Respiratory Care
F23 ☐☐☐ Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☐	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☐
Does the facility conduct experimental research?	F26	Yes ☐	No ☐
Is the facility part of a continuing care retirement community (CCRC)	F27	Yes ☐	No ☐

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ Hours waived per week F29_____
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ (M M D D Y Y) Hours waived per week F31_____

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program F32 Yes ☐ No ☐

FACILITY STAFFING

		A			B					C					D				
	Tag Number	Services Provided			Full - Time Staff (hours)					Part - Time Staff (hours)					Contract (hours)				
		1	2	3															
Administration	F33																		
Physician Services	F34																		
Medical Director	F35																		
Other Physician	F36																		
Physician Extender	F37																		
Nursing Services	F38																		
RN Director of Nurses	F39																		
Nurses with Admin. Duties	F40																		
Registered Nurses	F41																		
Licensed Practical/ Licensed Vocational Nurses	F42																		
Certified Nurse Aides	F43																		
Nurse Aides in Training	F44																		
Medication Aides/Technicians	F45																		
Pharmacists	F46																		
Dietary Services	F47																		
Dietitian	F48																		
Food Service Workers	F49																		
Therapeutic Services	F50																		
Occupational Therapists	F51																		
Occupational Therapy Assistants	F52																		
Occupational Therapy Aides	F53																		
Physical Therapists	F54																		
Physical Therapy Assistants	F55																		
Physical Therapy Aides	F56																		
Speech/Language Pathologist	F57																		
Therapeutic Recreation Specialist	F58																		
Qualified Activities Professional	F59																		
Other Activities Staff	F60																		
Qualified Social Workers	F61																		
Other Social Services Staff	F62																		
Dentists	F63																		
Podiatrists	F64																		
Mental Health Services	F65																		
Vocational Services	F66																		
Clinical Laboratory Services	F67																		
Diagnostic X-ray Services	F68																		
Administration and Storage of Blood	F69																		
Housekeeping Services	F70																		
Other	F71																		

Name of Person Completing Form	Time
Signature	Date

B. Provider Agreement

The Department of Inspections and Appeals must recommend a facility for certification as a nursing facility before a provider agreement may be issued. The effective date of a provider agreement may not be earlier than the date of certification.

Agreements between the Department and the facility are not time-limited. Provider agreements remain in effect until the facility changes owners or is no longer certified by the Department of Inspections and Appeals.

A transfer of ownership or operation terminates the participation agreement. A new owner or operator must establish that the facility meets the conditions for participation and must enter into a new agreement.

Facilities should complete form 470-0377, *Nondiscrimination Compliance Review for Title VI and Section 504 Regulations*, at the time of enrollment in the Medicaid program and periodically thereafter.

When it becomes necessary for the Department to cancels a Medicaid provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents.

1. Facsimile of Form 470-0369

A facsimile of form 470-0369, *Agreement for Nursing Facilities and Skilled Nursing Facilities*, follows.

2. Facsimile of Form 470-0377

A facsimile of form 470-0377, *Nondiscrimination Compliance Review for Title VI and Section 504 Regulations*, follows on pages 15-18.

Iowa Department of Human Services

AGREEMENT FOR NURSING FACILITIES AND SKILLED NURSING FACILITIES

This agreement is between:

( )

here referred to as "the facility," and the Iowa Department of Human Services, here referred to as "the Department."

This agreement covers facility services provided to eligible residents in Medicaid-certified beds and is effective .

As a provider in the Iowa Medicaid Program, the facility agrees and assures that:

1. The facility will maintain admission, discharge, fiscal and other records necessary to document services the facility furnished to recipients for at least five years.

2. The facility will afford the Department and the United States Department of Health and Human Services, through their authorized representatives, the right to review facility records and substantiate claims submitted for payment under the program. The Department will hold information in facility records confidential.

3. The allowable charges determined in accordance with the policy of the Department will be the full and complete payment for the services provided. Except for the amount of client participation, the facility will make no additional charges to residents or family members or any other person for any supplies or services required for the care of the resident.

   If any additional payment is received or will be received from any other sources, the facility will deduct that amount from the amount paid by the Department. Any overpayment made by the Department must be promptly returned to the Department. No Medicaid resident or responsible party must be charged for items not specifically requested by the resident or responsible party.

4. Payment and satisfaction of claims will be from federal and state funds. Any false claims, statements, and documents or concealment of a material fact may be prosecuted under applicable federal and state laws.

5. The facility will notify the Department 60 days before a planned change of ownership.

6. This agreement may be terminated under the following conditions:

   a. By the facility by giving 30 days notice to the Department of intent to terminate participation, or

   b. By the Department by giving 30 days notice to the facility:

      - After it has been determined that the facility is not in substantial compliance with the provisions of this agreement, or
      - When the facility's state license or certification has been terminated or suspended by the regulatory authority, or
      - For any other reason as provided by 441 Iowa Administrative Code 79.2(249A), "Sanctions Against Provider of Care."

7. The facility will not deny service on the basis of race, color, creed, national origin, sex, age, religion, political belief, or physical or mental disability.

8. The facility will comply with the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; the Age Discrimination Act of 1975, as amended; and the Americans with Disabilities Act of 1990.

9. The facility will provide residents with advance directive material as required by law.

10. The facility will abide by all policy and procedures as explained in the Iowa Administrative Code, the Medicaid Provider Manual for Nursing Facilities or Medicaid Skilled Nursing Facility Manual, and supplemental policy material distributed by the Department.

Authorized Signature of Provider	Authorized Signature of Department
Title	Chief, Bureau of Health Care Purchasing and Quality Management
Date	Date

Instructions:

Please complete and sign both copies and return one copy to: Iowa Department of Human Services, Division of Medical Services, Bureau of Health Care Purchasing and Quality Management, Hoover State Office Building, 5th Floor, Des Moines, Iowa 50319-0114.

We are also enclosing two copies of form 470-0377, *Nondiscrimination Compliance Review for Title VI and Section 504 Regulations*. Please complete both copies and retain one copy for your files. Return the other copy WITH NO DOCUMENTATION ATTACHED. If you have any questions concerning this matter, call 515-281-4623.

Iowa Department of Human Services

NONDISCRIMINATION COMPLIANCE REVIEW

The Department of Human Services has the responsibility for ensuring that Medicaid providers are in compliance with Title VI of the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973 as amended; and the Age Discrimination Act of 1975, as amended.

Identifying Information		
Facility Name	County	Phone ( )
Address		
Legal Auspices: ❑ Proprietary ❑ Nonprofit ❑ Governmental		Provider No.
Number of Beds _____ NF _____ Skilled _____ Other: _____ _____Total		

Documentation to support the information you provide on this form must be available for inspection at the facility.

Yes No **A. Admission Policies**

❑ ❑ 1. Does your facility have an admissions policy prohibiting discrimination based on race, color, age, national origin, or disability (mental or physical)?

❑ ❑ 2. If such a policy has been adopted, is it in writing and posted?

❑ ❑ 3. Have the following been notified in writing of the facility's policy of nondiscrimination: Note: If you answer no to any of the items, explain in Section G.

❑ ❑ Community
❑ ❑ Employees
❑ ❑ Residents
❑ ❑ Attending physicians

❑ ❑ 4. Is admission to your facility limited to membership in a defined group, e.g. fraternal organization, religious denomination, corporate employee, etc.?

If so, explain: _____

_____

5. Specify major referral sources for new admissions: _____

_____

6. What approximate percentage of your geographic service area population consists of racial minorities? _____%

B. Analysis of Residents Admitted During the Previous 12-Month Period

		RACIAL/ETHNIC GROUP IDENTIFICATION					With	Age	
	Total	White	Black	Hispanic	Amer. Ind. Alas. Nat.	Asian/ P.I.	Disabilities	Age 40+	39 or less
Men									
Women									
Total									

C. Type of Room Assignment

Number of residents in:	White	Black	Hispanic	Amer. Ind. Alas. Nat.	Asian/ P.I.	With Disabilities
Single room or in room alone						
Semiprivate or ward room with **no** minority people						
Semiprivate or ward room with **only** minority people						
Semiprivate or ward room with mixed racial/ethnic groups						
Total						

Yes No **D. General Availability of Facilities and Services**

❑ ❑ 1. Are all services and facilities available to and used by all residents without regard to race, color, age, national origin, or disability?

❑ ❑ 2. Can any licensed physician or therapist visit or treat a patient who is residing in this facility, regardless of race, color, age, national origin or disability of the patient or practitioner?

❑ ❑ 3. Has any qualified person within a disability been denied admission or excluded from participation in any applicable services or programs because the facility is structurally inaccessible? (If so, describe in Section G and state your plan for correction.)

❑ ❑ 4. Have persons with disabilities (or organizations representing them) assisted in identifying potential barriers to optimal participation by persons with disabilities in facility programs? (Please describe in Section G.)

❑ ❑ 5. Providers with fewer than 15 employees may refer persons with disabilities to an accessible provider only if no means other than a significant alteration in existing facilities available. Do you have a procedure which is followed to ensure that referrals are made under this condition?

❑ ❑ 6. Do you have a method of determining where services may be provided at alternate accessible sites in a nondiscriminatory manner?

❑ ❑ 7. When assessing a person's eligibility for your programs and services, you use the same procedures for disabled and non disabled?

❑ ❑ 8. Are appropriate services provided by your facility to persons with disabilities regardless of the nature of their disability?

❑ ❑ 9. Do you admit or treat alcohol or drug abusers in your programs or services on a nondiscriminatory basis?

❑ ❑ 10. Is there an effective means of communication for persons with hearing impairments receiving care in your facility?

❑ ❑ 11. Are auxiliary aids for persons with disabilities, including those with visual and hearing impairments, used to ensure equal benefit from services?

❑ ❑ 12. Has your staff been informed of the auxiliary aids which are available for service to persons who are disabled?

❑ ❑ 13. Does your facility have a written policy concerning hiring of bilingual employees to match bilingual characteristics of the population?

❑ ❑ 14. Does your facility have a written policy and procedure prohibiting discrimination in employment based on race, color, national origin, religion, sex, age, creed, and disability? If not, describe why in Section G.

E. Current Employment Breakdown

Staff Positions	White		Black		Hispanic		Amer. Ind. Alas. Nat.		Asian/ P.I.		With Disabilities	Age 40+	39 or less
	M	F	M	F	M	F	M	F	M	F			
Administrative													
RN/LPNs													
Nurses Aides													
Dietary													
Housekeeping & Maintenance													
Laundry													
Beauticians & Barbers													
Activities & Social Serv.													
Therapists & Consultants													
Other ( )													
Other ( )													
Total													

Yes No **F. Grievance**

❑ ❑ 1. Does your facility have a written grievance policy and procedure prohibiting discrimination in the delivery of services to residents based on race, color, national origin, age, or disability?

2. Has your facility received a complaint of discrimination based on:
If so, describe in Section G.

Services to Residents:

Yes	Number	No

Treatment of Employees:

Yes	Number	No

❑ ❑ 3. Is documentation maintained by your facility which can substantiate the nondiscriminatory practices on the basis of race, color, national origin, age, or disability? At the timed of an on-site compliance review or upon request, documentation must be made available.

G. Additional Information (Attach additional sheets, if necessary.)

CERTIFICATION

I CERTIFY THAT THE INFORMATION FURNISHED IN THIS CIVIL RIGHTS REVIEW REPRESENTS ACCURATELY THE POLICIES, PRACTICES, AND CURRENT STATUS OF THIS FACILITY.

Signature of Person Completing Form	Title	Date
Authorized Signature - Administrator	Title	Date

II. PHYSICAL ENVIRONMENT

All facilities that provide nursing facility care and also provide other types of care must set aside a distinct or identifiable part for the provision of the nursing facility care. It must be clearly identified and licensed by the Department of Inspections and Appeals.

The distinct part must be identifiable as a unit, such as a designated group of rooms, an entire ward or contiguous wards, wings, floor, or building. It must consist of all beds and related facilities in the unit where payment is being made for nursing facility services.

The distinct part must meet all requirements for a nursing facility. Hospitals participating as nursing facilities must meet all of the same conditions applicable to free-standing nursing facilities.

The facility must:

- Be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.
- Provide a safe, functional, sanitary and comfortable environment for residents, staff, and the public.
- Have adequate outside ventilation by means of windows or mechanical ventilation or a combination of the two.
- Provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.
- Provide adequate and comfortable lighting levels in all areas.
- Provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990, must maintain a temperature range of 71° to 81° Fahrenheit.
- Provide for the maintenance of comfortable sound levels.
- Maintain an effective pest control program so that the facility is free of pests and rodents.

The following sections explain the requirements for:

- Space and equipment.
- Resident rooms.
- Fire safety.

A. Space and Equipment

The facility must provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care.

The facility must provide one or more rooms designated for residents' dining and activities. These rooms must:

- Be well lighted.
- Be well ventilated, with nonsmoking areas identified.
- Be adequately furnished.
- Have sufficient space to accommodate all activities.

The facility must ensure that the residents' environment remains as free of accident hazards as possible. The facility must equip corridors with firmly secured handrails on each side.

The nurse's station must be equipped to receive resident calls through a communication system from resident rooms and toilet and bathing facilities.

The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

An emergency electrical power system must supply power when the normal electrical supply is interrupted that is adequate at least for:

- Lighting at all entrances and exits.
- Equipment to maintain the fire detection, alarm, and extinguishing systems.
- Life-support systems.

When life-support systems that are used have no nonelectrical backup, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) located on the premises.

The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.

B. Resident Rooms

Resident rooms must be designed and equipped for adequate nursing care, comfort and privacy of residents. Facilities must provide a safe, clean, comfortable and homelike environment, allowing the resident to use personal belongings to the extent possible.

Each resident room must be equipped with or located adjacent to toilet facilities unless the Department of Inspections and Appeals grants a waiver. Additionally, each resident room must be equipped with or located adjacent to bathing facilities.

Bedrooms must:

- Accommodate no more than four residents.
- Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single-resident rooms.
- Have direct access to an exit corridor.
- Be designed or equipped to ensure full visual privacy for each resident. In facilities initially certified after March 31, 1992, each bed (except in private rooms) must have ceiling-suspended curtains that extend around the bed, to provide total visual privacy in combination with adjacent walls and curtains.
- Have at least one window to the outside.
- Have a floor at or above grade level.

The facility must provide each resident with:

- A separate bed of proper size and height for the convenience of the resident.
- A clean, comfortable mattress.
- Bedding that is appropriate to the weather and climate, clean, and in good condition.
- Functional furniture appropriate to the resident's needs.
- Adequate storage facilities for the resident's personal effects, including individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

The Department of Inspections and Appeals may permit variations in requirements specified for rooms and furnishings in individual cases. To obtain a variance, the facility must demonstrate in writing that the variations are required by the special needs of the residents and will not adversely affect residents' health and safety.

C. Fire Safety

Except as provided below, the facility must meet the applicable provisions of the 1985 edition of the Life Safety Code of the National Fire Protection Association.

A facility that on October 26, 1982, complied with or without waivers with the requirements of the 1967, 1973, or 1981 edition of the Life Safety Code is considered to meet this requirement, as long as the facility continues to remain in compliance with those editions of the Code.

A facility that on May 8, 1988, complied with or without waivers with the 1981 or 1985 edition of the Life Safety Code is considered to meet this requirement, as long as the facility continues to remain in compliance with that edition of the Code.

Medicaid nursing facilities and Medicaid distinct-part nursing facility providers may request a waiver of Life Safety Code requirements in accordance with subsection 1919(d)(2)(B)(i) of the Social Security Act. The Department of Inspections and Appeals sends these requests to the Health Care Financing Administration Regional Office for review and approval.

III. ADMINISTRATION

A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.

The facility must operate and provide services in compliance with all applicable federal, state, and local laws, regulations and codes. The facility must also comply with accepted professional standards and principles that apply to professionals providing services in such a facility.

In addition to compliance with these rules, facilities must meet the applicable provisions of other regulations of the U.S. Department of Health and Human Services. These include, but are not limited to regulations pertaining to:

- Nondiscrimination on the basis of race, color, national origin, age, or disability.
- Protection of human subjects of research.
- Fraud and abuse.

Although these regulations are not in themselves considered requirements under these rules, their violation may result in the termination or suspension of payment, or the refusal to grant or continue payment with federal funds.

The following sections detail requirements for:

- Disclosure of facility ownership.
- Facility policies and procedures.
- Facility records.

A. Disclosure of Ownership

The facility must supply the following information to the Department of Inspections and Appeals when it is surveyed, for submission to the U.S. Department of Health and Human Services:

- The name and address of each person with an ownership or control interest in the facility or any subcontractor in which the facility has a direct or indirect ownership interest totaling five percent or more.
- Whether any of the persons named is related to another as spouse, parent, child, or sibling.
- The name of any other facility in which any person with an ownership or control interest in the facility also has an ownership or control interest. This requirement applies to the extent that the facility can obtain the information by requesting it in writing from the person. The facility must keep copies of these requests and responses and make them available to the Department on request.

The Department is not allowed to enter into a Medicaid provider agreement with a facility that does not disclose this information. The Department of Inspections and Appeals collects this information on form HCFA-1513, *Disclosure of Information and Control Interest Statement*. This information is public information.

The following sections include:

- A facsimile of the form required for reporting facility ownership.
- Requirements for reporting changes in ownership.

1. Facsimile of HCFA-1513

See the following pages for instructions for completing form HCFA-1513, *Disclosure of Ownership and Control Interest Statement*, and a sample of the form.

Submit this form with the initial request for Medicaid certification and upon each survey of the facility.

Page 28 was intentionally left blank.

2. Report of Changes

If a change occurs in any of the following, the facility must provide written notice of the identity of each new person or company to DIA at the time of change:

- Persons with an ownership or control interest.
- The officers, directors, agents, or managing employees.
- The corporation, association, or other company responsible for the management of the facility.
- The facility's administrator or director of nursing.

A participating facility contemplating termination of participation or negotiating a change of ownership must provide the Department of Human Services with at least 60 days prior notice.

B. Policies and Procedures

The facility must have written policies and procedures that govern all areas of service provided by the facility. These documents must be available to staff, residents, their families or legal representatives, and the public.

Policies must describe the way in which services will be provided, directly or under written agreement. The facility must establish and maintain identical policies and practices regarding the provision of services for all persons regardless of source of payment. (See also Section V, **PROVISION OF SERVICES**.)

Facility policies must describe:

- The care of residents in emergencies.
- The care of residents when acutely ill, mentally or emotionally disturbed, or difficult to manage.
- The protection afforded residents' property rights and monies.
- Arrangements for residents to receive visitors and for residents to make outside visits (See also Section VI, **RESIDENT RIGHTS**.)

Facility policy must include procedures for transferring the resident when the facility can no longer meet their needs. (See also Section VIII, **TRANSFER AND DISCHARGE**.)

The following sections describe the requirements for policies and procedures on:

- Nondiscrimination.
- Facility admissions.
- Notice of resident rights and services.
- Staff treatment of residents.
- Infection control.
- Disaster and emergency preparedness.

1. Nondiscrimination

The facility must:

- Adopt written statements that explain the facility's nondiscrimination policies and practices.
- Keep these policies current.
- Include these policies in any publication of staff regulations or public information brochures.
- Periodically review the policies with employees.

Where appropriate, the facility must provide copies of these statements to its residents, employees, attending physicians and other contractors providing services to residents.

2. Admissions Policy

The facility's policies must describe the categories of residents accepted and not accepted. The facility must use its referral sources in a manner that ensures an equal opportunity for admission without regard to a person's race, color, or national origin, in relation to the population of the potential service area.

The facility must admit all residents without discrimination and must not make inquiries regarding race, color, or national origin before admission. Admission must not be restricted to members of any group or order that discriminates.

Facilities must:

- Apply policies regarding deposits, extension of credit, and other financial matters uniformly and without regard to race.
- Make information regarding the price and availability of accommodations uniformly available to all without regard to race, color, or national origin.

The facility must not require a third-party guarantee of payment as a condition of admission, expedited admission, or continued stay in the facility. The facility may require a person who has legal access to a resident's income or resources to sign a contract to provide facility payment from the resident's income or resources, without incurring personal financial liability.

A facility must not require residents or potential residents to waive their rights to Medicare or Medicaid. A facility must not require oral or written assurance that residents or potential residents are not eligible for Medicare benefits or will not apply for them.

For a Medicaid-eligible person, the facility must not charge, solicit, accept, or receive any gift, money, donation, or other consideration in addition to the Medicaid payment as a precondition of admission, expedited admission, or continued stay in the facility.

A facility may solicit, accept, or receive a charitable, religious or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid-eligible resident.

The facility must give proper notice of the availability and cost of services to residents. The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirements.

The state is not required to offer additional services on behalf of a resident other than services defined in this manual as included in the term "nursing facility services." A facility may charge a Medicaid-eligible resident for other items and services that the resident has requested and received, so long as:

- Notice requirements are met, and
- The facility does not condition the resident's admission or continued stay on the request for and receipt of these additional services.

3. Notice of Rights and Services

The facility must inform the resident of the resident's rights and all rules governing resident conduct and responsibilities during the stay in the facility. This information must be given both orally and in writing in a language that the resident understands. Residents must acknowledge receipt of this information and any amendments to it in writing.

Before or upon admission, and periodically during the resident's stay, the facility must inform each resident of:

- The services available in the facility, and
- Charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

At the time of admission, or when the resident becomes eligible for Medicaid, the facility must inform the resident in writing of the items and services included in nursing facility services under the Medicaid program for which the resident may not be charged.

The facility must also inform the resident in writing of those other items and services that the facility offers for which the resident may be charged, and the amount of charges for those services. The facility must also inform the resident when it makes changes to these items and services.

Before or upon admission and during the resident's stay, the facility must furnish a written description of legal rights that includes:

- A description of the manner of protecting personal funds.
- A statement that the resident may file a complaint with the Department of Inspections and Appeals concerning resident abuse, neglect, or misappropriation of the resident's property in the facility.
- A description of the requirements and procedures for establishing eligibility for Medicaid. This includes the right to request an assessment which:
  - Determines the extent of a couple's nonexempt resources at the time of institutionalization, and
  - Attributes to the community spouse an equitable share of resources that cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in the resident's process of spending down to Medicaid eligibility levels.

The facility must provide residents and applicants for admission with oral and written information about:

- How to apply for and use Medicare and Medicaid benefits, and
- How to receive refunds for previous payments covered by these benefits.

The facility must display written information about this prominently in the facility. The facility must also provide the resident with the pamphlet *"Medicaid for People in Nursing Homes and other Care Facilities,"* Comm. 52. (See Section VII, **MEDICAID ELIGIBILITY**, for information about this and other publications that are available for this purpose.)

Also at the time of admission, the nursing facility must provide written information to each resident that explains the resident's rights under state law to make decisions concerning medical care, including:

- The right to accept or refuse medical or surgical treatment, and
- The right to formulate advance directives and the nursing facility's policies regarding the implementation of these rights.

"Advance directive" means written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the resident is incapacitated.

The nursing facility must:

- Document in the resident's medical record whether or not the resident has executed an advance directive.
- Ensure compliance with requirements of state law regarding advance directives.
- Provide for education for staff and the community on issues concerning advance directives.

The nursing facility must not condition the provision of care or otherwise discriminate against a resident based on whether or not the resident has executed an advance directive. (Under Iowa law, a nursing facility may object to implementing an advance directive on the basis of conscience.)

4. Staff Treatment of Residents

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, abuse of residents and misappropriation of resident property. Facility staff must not use verbal, mental, sexual, or physical abuse (including corporal punishment), or involuntary seclusion of residents.

The facility must not employ persons who:

- Have been found guilty by a court of law of abusing, neglecting, or mistreating people, or
- Have had a finding entered into the state Nurse Aide Registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property.

The facility must report to the state Nurse Aide Registry or licensing authorities any knowledge it has of court action against an employee that indicates unfitness for service as a nurse aide or other nursing facility staff.

The facility must ensure that the following are reported immediately to the administrator of the facility or to other officials (including the Department of Inspections and Appeals) in accordance with state law through established procedures:

- All alleged violations involving mistreatment; neglect or abuse, including injuries of unknown source.
- Misappropriation of resident property.

The facility must have evidence that all alleged violations are thoroughly investigated. The facility must prevent further abuse while the investigation is in process.

Within five working days of the incident, facility staff must report the results of all investigations to the administrator or the administrator's designated representative or to other officials (including the Department of Inspections and Appeals) in accordance with state law. If the alleged violation is verified, the facility must take appropriate corrective action.

5. Infection Control

The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents live and to help prevent the development and transmission of disease and infection.

Under the facility's infection control program, it must investigate, control, and prevent infections in the facility. The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

The program must determine what procedures, such as isolation, should be applied to an individual resident. When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

The facility must maintain a record of incidents and corrective actions related to infections.

6. Disaster and Emergency Preparedness

The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

The facility must train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out staff drills using those procedures.

C. Records

At a minimum, the nursing facility should maintain the following records:

- All records required by the Department of Public Health and the Department of Inspections and Appeals, including:
  - Resident or patient records
  - Incident records
  - Death records
  - Patient activities program records
  - Financial and statistical records
- All records required by the agreement for nursing facilities, including:
  - Medical records.
  - Records of all treatments, drugs, and services for which Medicaid payment has been or will be made, including the authority for the treatment, drugs, or services and the date of administration.
  - Documentation in each patient's record that will enable the Department to verify that each charge is proper.
  - Financial records maintained in the standard, specified form including the facility's most recent *Financial and Statistical Report*, form 470-0030.

- Records required by federal regulations, including:
  - Resident accounts.
  - In-service education records.
  - Inspection reports pertaining to conformity with federal, state, and local laws.
  - Resident personal records.
  - Resident medical records.
  - Disaster-preparedness reports.

Facilities must maintain records uniformly without discrimination for all residents. Identification by race, color, and national origin on records is not considered to be discriminatory. Facilities may use such identification to demonstrate compliance with Title VI.

Upon an oral or written request, the resident or the resident's legal representative has the right to access all records pertaining to the resident within 24 hours, including clinical records.

After receipt of the records for inspection, the resident or representative has the right to purchase photocopies of the records or any portions of them upon request. The resident must give two working days' advance notice to the facility. The facility may charge a cost for copies, not to exceed the community standard.

Facilities must retain resident personal records for a minimum of five years after death or discharge. Records not pertaining to individual residents must also be retained in the facility for a minimum of five years. All records must be retained within the nursing facility upon change of ownership.

1. Clinical Records

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices. The records must be complete, accurately documented, readily accessible, and systematically organized. The clinical record must contain:

- Sufficient information to identify the resident.
- A record of the resident's assessments.
- The plan of care and services provided.
- The results of any preadmission screening conducted by the state.
- Progress notes.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required:

- By law for transfer to another health care institution.
- By third-party payment contract.
- By the resident.

The facility must safeguard clinical record information against loss, destruction, or unauthorized use. Clinical records must be retained for:

- The period of time required by state law.
- For a minor, three years after a resident reaches legal age under state law.
- Five years from the date of discharge when there is no requirement in state law.

2. Accounting for Residents' Personal Funds

The facility must establish and maintain a system that ensures a full, complete, and separate accounting of each resident's personal funds entrusted to the facility on the resident's behalf.

Accounting must be according to generally accepted accounting principles. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The facility must purchase a surety bond or otherwise provide assurance satisfactory to the Department of Inspections and Appeals and the Department of Human Services to ensure the security of all personal funds of residents deposited with the facility.

Nursing facilities do not have the option of refusing to handle a resident's personal allowance funds if requested to do so. However, residents may elect to handle their own funds if they wish.

Facilities must maintain two types of accounts to handle resident personal allowance funds:

- Maintain a resident's personal funds that do not exceed $50 in a non-interest-bearing account, an interest-bearing account, or petty cash fund.
- Deposit any residents' personal funds in excess of $50 in an interest-bearing account that:
  - Is separate from any of the facility's operating accounts, and
  - Credits all interest earned on the resident's funds to that account.

The main function of the larger individual checking accounts is to act as a depository to generate interest and retain funds that later will be placed in the petty cash fund.

In pooled accounts, there must be a separate accounting for each resident's share. If the facility maintains a single joint account, interest earned must be prorated periodically, normally upon receipt of the monthly bank statement, and credited to a separate ledger card for each resident.

If the facility opens an individual checking account for each resident, interest earned is automatically credited to each respective account. With this method, a second set of ledger cards is not necessary, as the individual check book register serves as a ledger card to record deposits and withdrawals.

Deposit the first $50.00 of each resident's funds, or entire total if less than $50.00, into a petty cash fund that consists solely of resident's funds. Set up a new individual ledger card for each resident that reflects the initial $50.00 deposit into the petty cash fund.

Deposit all monthly personal allowance funds received into the larger account before placing them in the petty cash fund for resident use. Never make the monthly deposits directly into the petty cash fund.

Keep receipts for large purchases and vouchers for smaller items in individual envelopes for each resident. The receipts or vouchers must indicate the resident's name, date, amount, and items purchased and must be retained in the petty cash fund box.

Whenever possible, the resident should sign a voucher for all cash received from the petty cash fund, regardless of its intended use. This is an adequate receipt for that type of withdrawal. The total cash on hand plus vouchers should equal the total of all ledger cards for the petty cash fund.

Make the ledger and receipts for each resident available for periodic audits by an accredited Department representative. When the Department's representative makes an audit certification at the bottom of the ledger sheet, supporting receipts may then be destroyed.

When a resident's account balance gets low in the petty cash fund, post the vouchers to the ledger cards. As the petty cash fund amount for a resident is used, draw an amount to replenish the fund to $50.00 from the larger account and placed into the petty cash fund.

Make all purchases other than large items through the petty cash fund. Make large purchases directly through the individual checking account only. Send quarterly statements to the resident or the resident's legal representatives on request.

Notify each resident who receives Medicaid benefits when the amount in the account reaches $200 less than the SSI resource limit for one person. Notify residents that they may lose eligibility for Medicaid or for SSI if the amount of the account, in addition to the resident's other nonexempt resources, reaches the SSI resource limit for one person.

Within 30 days after a resident's death, convey the resident's funds and a final accounting of those funds to the person or probate jurisdiction administering the resident's estate.

Obtain a receipt from the next of kin or the resident's guardian before releasing the balance of the deceased resident's personal needs funds and any money derived from the sale of property or possessions.

If the resident has no guardian, any funds left in the personal needs account revert to the Iowa Department of Human Services. In the event that an estate is opened, the Department must turn the funds over to the estate.

IV. STAFF

The facility must employ on a full-time, part-time, or consultant basis those professionals necessary to carry out the provisions of these conditions of participation. Professional staff must be licensed, certified or registered in accordance with applicable state laws.

If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility.

Arrangements or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility and for the timeliness of the services.

The governing body appoints the administrator. The administrator must be licensed by the state and must be responsible for management of the facility.

The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility.

The following sections explain requirements for:

- Nurses.
- Nurse aides.
- Nurse aide training and competence evaluation programs (NATCEP).
- Dietary staff.
- Consultant pharmacist.
- Social worker.
- Activities staff.

A. Nurses

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

Except when waived, the facility must designate a registered nurse to serve as the director of nursing on a full-time basis. Except when waived, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

Except when waived, the facility must use the services of a registered nurse for at least eight consecutive hours per day, seven days a week. Except when waived, the facility must provide services by sufficient numbers of licensed nurses on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.

A facility may request a waiver from these requirements. A waiver may be granted if the following conditions are met:

- The facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts, including offering wages at the community prevailing rate for nursing facilities, to recruit appropriate personnel.
- The Department of Inspections and Appeals determines that a waiver of the requirement will not endanger the health or safety of facility residents.
- The Department of Inspections and Appeals finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility. This type of waiver is subject to annual review by the Department of Inspections and Appeals.

In granting or renewing a waiver, the Department of Inspections and Appeals may require a facility to use other qualified, licensed personnel.

The Department of Inspections and Appeals must provide notice of the waiver granted to the state long-term care ombudsman in the Department of Elder Affairs and to the protection and advocacy system in the state for the mentally ill and mentally retarded.

The nursing facility that is granted a personnel waiver must notify residents of the facility or, where appropriate, the guardians or legal representatives of the residents and members of their immediate families of the waiver.

B. Nurse Aides

The facility must provide services by sufficient numbers of other nursing personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.

"Nurse aide" means any person providing nursing or nursing-related services to residents in a facility who is not:

- A licensed health professional.
- A registered dietitian.
- A person who volunteers to provide services without pay.

("Licensed health professional" means a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapy assistant; registered or licensed professional nurse; or licensed or certified social worker.)

The facility must ensure that nurse aides are able to demonstrate competency in skills and technique necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

Nurse aides may provide care only in those skill areas in which they have received training and have demonstrated competence. Before employment or within four months after employment, all nurse aides must pass a state-approved competency evaluation. (See Item IV.C. for requirements for nurse aide training and competency evaluation programs.)

The following sections explain requirements for:

- Demonstration of competency.
- Use of the Nurse Aide Registry.
- Nurse aides' rights and responsibilities in relation to the Registry.
- In-service training and performance review for nurse aides.

1. Demonstration of Competency

A facility must not use any person working in the facility as a nurse aide for more than four months (on a permanent, temporary, per diem, leased, or other basis) unless that person is competent to provide nursing and nursing-related services. The person must either:

- Have completed a state-approved training and competency evaluation program, or
- Have completed a state-approved competency evaluation, or
- Have been deemed or determined competent by the Department of Inspections and Appeals.

A facility may employ a person who does not meet these requirements as a nurse aide for less than four months if the person:

- Is a permanent employee, and
- Is in a state-approved nurse aide training and competency evaluation program.

When a person has not performed paid nursing or nursing-related services for a continuous period of 24 consecutive months since the most recent completion of a training and competency evaluation program, the facility must require the person to complete a new training and competency evaluation program or pass the competency evaluation again.

(A person may be employed as a nurse aide in a nursing facility, skilled nursing facility, certified or licensed hospital, federally certified home health agency, hospice, ICF/MR, or NF/MI to meet this employment requirement.)

No nurse aide who is employed by a facility, or who has received an offer of employment from a facility, on the date on which the aide begins a nurse aide training and competency evaluation program may be charged for any portion of the program. This includes any fees for textbooks or other required course materials.

A facility must reimburse the nurse aide for costs incurred in completing the program when a person whose training costs were not covered by a facility becomes employed by the facility or receives an offer of employment from the facility within 12 months after completing the program.

The facility must reimburse the aide on a pro rata basis during the period in which the facility employs the person as a nurse aide. The formula for paying the nurse aide on a prorated basis is as follows:

. 1. Add all costs incurred by the aide for the course, books, and tests.
2. Divide this total by 12 to prorate the costs over a one-year period and establish a monthly rate.

Reimburse the aide at the monthly rate each month the aide works at the facility until one year from the time the aide completed the course.

2. Nurse Aide Registry Verification

Facility staff must contact the Nurse Aide Registry before any person is hired as a nurse aide to determine if the person:

- Is on the Registry.
- Has completed an approved training course.
- Has passed the competency test.
- Has any founded abuse reports on the Registry record.

A facility must check with all state nurse aide registries it has reason to believe contain information on an individual before using that individual as a nurse aide.

To obtain information, facility staff need the nurse aide's social security number and the last four digits of the facility license number.

The facility must ensure that the name of each person employed as a nurse aide in a Medicaid-certified facility in Iowa is submitted to the Nurse Aide Registry.

Within 30 days of when a nurse aide is hired and when a nurse aide's employment ends, the facility must complete form 427-0497, *Nurse Aide Employment Status Report*. This form may be obtained from and must be sent to the Nurse Aide Registry.

All information retained by the Nurse Aide Registry must be available to the public. This includes the name and social security number of the nurse aide, founded abuse reports, and a brief statement from the nurse aide, if available, disputing the findings of abuse. Other information collected will be kept for statistical purposes.

3. Registration Rights and Responsibilities

Persons employed as nurse aides must complete form 427-0496, *Nurse Aide Registry Application*, within the first 30 days of employment. A certified nurse aide who is not employed may also apply for inclusion on the Registry by submitting form 427-0496. This form may be obtained by calling or writing the Nurse Aide Registry.

Information will not be placed on the Registry until the nurse aide has successfully completed a competency evaluation. When the Registry has received and entered the required training and testing information, the Registry will send the nurse aide a letter that includes all the information the Registry has on the nurse aide.

A nurse aide may obtain a copy of the information on the Registry by writing or calling the Nurse Aide Registry and requesting the information. The letter requesting the information must include the nurse aide's social security number, current or last facility of employment and date of birth.

When there is an allegation of abuse against a nurse aide, the Department of Inspections and Appeals will investigate the allegation. When the Department of Inspections and Appeals finds an act of abuse, the nurse aide named will be notified of this finding and the right to a hearing.

The nurse aide must have 30 days to request a hearing. The request must be in writing and must be sent to the Nurse Aide Registry. The hearing must be held according to the appeals rules of the Department of Inspection and Appeals.

Information will not be placed on the Registry until an abuse allegation has been founded. If the nurse aide fails to appeal, the Nurse Aide Registry will include a notation after 30 days that the nurse aide has a founded abuse report on record.

If the nurse aide appeals, the notation must be made when all appeals are exhausted, if the final decision indicates the nurse aide performed an abusive act.

4. In-Service Training and Performance Review

The facility must provide 12 hours of in-service training each year to ensure that persons used as nurse aides are competent to perform services as nurse aides. Each nurse aide must receive and be compensated for 12 hours of in-service training each year.

Training may be offered for groups or individuals. Training for individuals may be performed on the unit as long as it is directed toward specific skill improvement, is provided by trained staff, and includes a return demonstration recorded on a checklist. In-service education must include training for persons providing nursing and nursing-related services to residents with cognitive impairments.

The facility must:

- Provide regular performance review to ensure that persons used as nurse aides are competent to perform services as nurse aides.
- Determine the format and content of the performance evaluation.
- Conduct an evaluation of each aide's work performance at least annually.
- Keep a record of the performance evaluation in the aide's personnel file.

C. Nurse Aide Training and Competency Evaluation Programs

The Department has designated the Department of Inspections and Appeals (DIA) to approve required nurse aide training and testing programs. Before the DIA approves a nurse aide training and competency evaluation program (NATCEP), the DIA determines whether the program meets the requirements described in this section. The DIA also reviews the programs in the course of all facility surveys.

The following sections describe:

- The NATCEP approval process.
- General NATCEP requirements.
- Requirements for NATCEP instructors.
- Requirements for NATCEP curriculum.
- Requirements for NATCEP records and reports.
- Requirements for competency evaluations.
- Exceptions to facility ineligibility to provide a NATCEP
- Facsimile of the exception request form.

1. Approval Process

Facilities must submit applications to the DIA before a new program begins and every two years thereafter on form 427–0517, *Application for Nurse Aide Training*.

Within 90 days of the date of a request or receipt of additional information from the requester, the DIA will:

- Advise the requester whether or not the program has been approved; or
- Request additional information from the requesting entity.

The DIA will grant approval of a NATCEP for a period no longer than two years. When there are substantive changes made to a program within the two-year period, the program must notify the DIA, and the DIA will review that program.

Except as provided under item C.7, below, the DIA will not approve a NATCEP offered by or in a facility which, in the previous two years:

- Has operated under a nurse staffing waiver for a period in excess of 48 hours per week; or
- Has been subject to an extended or partial extended survey; or
- Has been assessed a civil money penalty of not less than $5,000; or
- Has operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or

- Pursuant to state action, was closed or had its residents transferred; or
- Has been terminated from participation in the Medicaid or Medicare program; or
- Has been denied Medicaid payment.

The DIA will withdraw approval of a NATCEP offered by or in a facility when one of these events occurs.

The DIA may withdraw approval of a NATCEP if the DIA determines that any of the requirements for approval are not met. The DIA will withdraw approval of a NATCEP if the entity providing the program refuses to permit unannounced visits by the DIA.

If the DIA withdraws approval of a NATCEP, the DIA will notify the program in writing, indicating the reasons for withdrawal of approval of the program. Students who have started the program will be allowed to complete the course.

To secure approval for a competency evaluation program, submit a copy of the evaluation plan and procedures to DIA. The DIA will make a decision within 90 days of receipt of the application. If approval is denied, the DIA notification will include the reason for not giving approval and the applicable rule citation.

2. General Requirements

For a NATCEP to be approved by the DIA, it must, at a minimum:

- Consist of no less than 75 clock hours of training Including at least:
  - 15 hours of laboratory experience.
  - 30 hours of classroom instruction.
  - 30 hours of supervised clinical training.
- Ensure that students do not independently perform any services for which they have not been trained and found proficient by the instructor.
- Ensure that students who are providing services to residents are under the general supervision of a licensed nurse or a registered nurse.
- Contain information regarding competency evaluation through written or oral and skills testing.

The first 16 hours of classroom instruction must occur before the nurse aide has resident contact. "Supervised clinical training" means training in a setting in which the trainee demonstrates knowledge while performing tasks on a resident under the general supervision of a registered nurse or licensed practical nurse.

The classroom must have appropriate equipment, be of adequate size, and not interfere with resident activities.

3. Instructors

The training of nurse aides must be performed by or under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience. At least one year of this experience must be in the provision of long-term care facility services.

Instructors must be registered nurses and must have completed a course in teaching adults or have experience teaching adults or supervising nurse aides. Other personnel from the health professions may supplement the instructor. Supplemental personnel must have at least one year of experience in their fields.

The ratio of qualified trainers to students must not exceed one instructor for every ten students in the clinical setting.

In a facility-based program, when the director of nursing is a registered nurse, the training of nurse aides may be performed under the general supervision of the director of nursing for the facility. The director of nursing is prohibited from performing the actual training.

4. Curriculum

The curriculum of the nurse aide training program must include:

- At least a total of 16 hours of training in the following areas before any direct contact with a resident:
  - Communication and interpersonal skills.
  - Infection control.
  - Safety and emergency procedures including the Heimlich maneuver.
  - Promoting residents' independence.
  - Respecting residents' rights.
- Basic nursing skills:
  - Taking and recording vital signs.
  - Measuring and recording height and weight.
  - Caring for the residents' environment.
  - Recognizing abnormal changes in body functioning and the importance of reporting these changes to a supervisor.
  - Caring for residents when death is imminent.
- Personal care skills, including, but not limited to:
  - Bathing.
  - Grooming, including mouth care.
  - Dressing.
  - Toileting.
  - Assisting with eating and hydration.
  - Proper feeding techniques.
  - Skin care.
  - Transfers, positioning, and turning.
- Mental health and social service needs:
  - Modifying aide's behavior in response to residents' behavior.
  - Awareness of developmental tasks associated with the aging process.
  - How to respond to resident behavior.
  - Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity.
  - Using the resident's family as a source of emotional support.

- Care of cognitively impaired residents:
  - Techniques for addressing the unique needs and behaviors of persons with dementia (Alzheimer's and others).
  - Communicating with cognitively impaired residents.
  - Understanding the behavior of cognitively impaired residents.
  - Appropriate responses to the behavior of cognitively impaired residents.
  - Methods of reducing the effects of cognitive impairments.
- Basic restorative services:
  - Training the resident in self-care according to the resident's ability.
  - Use of assistive devices in transferring, ambulation, eating and dressing.
  - Maintenance of range of motion.
  - Proper turning and positioning in bed and chair.
  - Bowel and bladder training.
  - Care and use of prosthetic and orthotic devices.
- Residents' rights:
  - Providing privacy and maintenance of confidentiality.
  - Promoting the residents' rights to make personal choices to accommodate their needs.
  - Giving assistance in resolving grievances and disputes.
  - Providing needed assistance in getting to and participating in resident and family groups and other activities.
  - Maintaining care and security of residents' personal possessions.
  - Promoting the residents' rights to be free from abuse, mistreatment, and neglect and the need to report any instances of this type of treatment to appropriate facility staff.
  - Avoiding the need for restraints in accordance with current professional standards.

5. Records and Reports

Nurse aide education programs approved by the DIA must:

- ♦ Keep a list of faculty members and their qualifications available for review.
- ♦ Complete a lesson plan for each unit which includes behavioral objectives, a topic outline, and student activities and experiences.
- ♦ Notify the DIA:
  - Of dates of classroom and clinical sessions and location of classrooms and clinical practice sites before each course begins.
  - If a scheduled course is canceled.
  - When a facility or other training entity will no longer be offering nurse aide training courses.
  - Whenever the person coordinating the training program is hired or terminates employment.
- ♦ Provide each nurse aide a record of skills for which the nurse aide has been found competent during the course and which may be performed before completion of the competency evaluation.
- ♦ Provide the student evidence of having successfully completed the course within 30 days of the last class period.

6. Competency Evaluation

The competency examination must be administered and evaluated only by an entity approved by the DIA. The administering entity cannot be a skilled nursing facility that participates in Medicare or a nursing facility that participates in Medicaid.

A competency evaluation program must contain a written or oral portion and a skills demonstration portion. The program must allow an aide to choose between a written and oral examination. The person responsible for administering a competency evaluation must provide secure storage of the evaluation instruments when they are not being administered or processed.

The written or oral portion of the competency evaluation must:

- Address each of the course requirements listed in Item C.4.
- Be tested for reliability and validity using a nationally recognized standard as determined by the Department of Education.
- Be developed from a pool of test questions, only a portion of which is used in any one examination.
- Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations.
- Be in English, unless the prevailing language used in the facility where a nurse aide will be working is other than English.
- If oral, be read from a prepared text in a neutral manner.

The skills demonstration evaluation must consist of a demonstration of randomly selected items drawn from a pool consisting of tasks generally performed by nurse aides. This pool of skills must include all of the personal care skills listed in Item C.4.

The skills demonstration part of the evaluation must be performed in a facility or laboratory setting comparable to the setting in which the person will function as a nurse aide. It must be administered and evaluated by a registered nurse with at least one year's experience in providing care for the elderly or the chronically ill of any age.

At the nurse aide's option, the competency evaluation may be conducted at the facility in which the nurse aide is or will be employed, unless the facility is prohibited from being a competency evaluation site.

The DIA may permit the competency evaluation to be proctored by facility personnel if the DIA finds that the procedure adopted by the facility ensures that the competency evaluation program:

- Is secure from tampering.
- Is standardized and scored by a testing, educational, or other organization approved by the DIA.
- Requires no scoring by facility personnel.

The DIA will retract the right to proctor nurse aide competency evaluations from facilities in which the DIA finds any evidence of impropriety, including evidence of tampering by facility staff.

A score of 70 percent or above is passing for both the written or oral and skills demonstration parts of the test. The competency testing entity must:

- Inform the nurse aide of the test score within 30 calendar days of the completion of the test.
- Inform the Nurse Aide Registry of the nurse aide's scores within 20 calendar days after the test is administered.

If the person does not complete the evaluation satisfactorily, the person must be advised in writing within ten working days after the test is scored:

- Of the areas which the person did not pass.
- That the person has three opportunities to take the evaluation.

Each person has three opportunities to pass each part of the test. If one part of the test is failed, only that part need be taken a second or third time. If either part of the test is failed three times, the 75-hour course must be taken or retaken before the test can be taken again.

7. Exceptions to Facility Ineligibility

When a facility is ineligible to offer an approved nurse aide training and competency evaluation program, the DIA may grant an exception for 75-hour nurse aide training courses offered in (but not by) the facility under the following conditions:

- The facility submits a request to the DIA (form 470-3494) for a waiver for each 75-hour nurse aide training course to be offered in (but not by) the facility. (A facsimile of the form follows.)
- The 75-hour nurse aide training is offered in a facility by an approved NATCEP.

- No other NATCEP program is offered within 30 minutes travel from the facility, unless the facility can demonstrate the distance or program would create a hardship for program participants.
- The facility is in substantial compliance with the federal requirements related to nursing care and services.
- The facility is not designated by DIA as a poor performing facility.
- Employees of the facility do not function as instructors for the program unless specifically approved by DIA.
- The NATCEP sponsoring the 75-hour nursing aide training course is responsible for program administration and for assuring that program requirements are met.
- The NATCEP submits to the DIA an evaluation indicating that an adequate teaching and learning environment exists for conducting the course.
- The NATCEP has developed policies for communicating and resolving problems encountered during the course, including notice by the facility to the program instructor and students on how to contact the DIA to register any concerns encountered during the course.
- Upon completion of the course, the program instructor and students submit an evaluation of the course to the DIA.

8. Facsimile of Nurse Aide Education Program Waiver Request

The following pages contain a sample of form 470-3494, *Nurse Aide Education Program Waiver Request*.

Iowa Department of Human Services

NURSE AIDE EDUCATION PROGRAM WAIVER REQUEST

Section I - Completed by Facility Requesting the Waiver

LTC Facility Requesting the Waiver		
Address		Phone ( )
City	State	Zip

Reason for Waiver Request:

- ❑ No other approved nurse aide training program within a reasonable distance from the facility. (Reasonable distance is defined as 30 minutes travel time each way from the facility.)
- ❑ Classes not currently being offered at an approved site within a reasonable distance.
- ❑ Classes within a reasonable distance are not offered during time frames to meet student and facility needs. Please specify:

_____

_____

_____

_____

_____

_____

_____

_____

List all NATCEP approved training sites contacted for course availability. Specify date of next course, distance and travel time to each site contacted.

NATCEP Program	Individual Contacted	Training Site	Course Date	Travel Time

Facility Administrator's Signature	Date

Section II - Completed by NATCEP Course Sponsor

Course Sponsor		
Address		Phone ( )
City	State	Zip

Course NATCEP Program Coordinator's Name	RN/License No.
Course Instructor (if different than program coordinator listed above)	RN/License No.

Is the instructor an employee of the facility? ❑ Yes ❑ No

Course Start Date _____ Course Completion Date _____

Describe the evaluation process used to determine an adequate teaching/learning environment exists for conducting a course. An evaluation should address adequacy of classroom, availability of equipment and oversight of the clinical component of the course.

Describe how the course will be evaluated and how the evaluation process will be used to improve future courses.

At the completion of each course the NATCEP course instructor and students must submit the course evaluations to the Department of Inspections and Appeals, Division of Health Facilities.

_____ _____

RN Program Coordinator Signature Date

D. Dietary Staff

The facility must employ a qualified dietitian either full-time, part-time or on a consultant basis. If a qualified dietitian is not employed full time, the facility must designate a person to serve as the director of food services who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is licensed by the Iowa Board of Dietetic Examiners.

The facility must employ sufficient support personnel competent to carry out the functions of the dietary services.

E. Consultant Pharmacist

The facility must employ or obtain the services of a licensed pharmacist who:

- Provides consultation on all aspects of the provision of pharmacy services in the facility.
- Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.
- Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

The licensed pharmacist must provide:

- Consultation on methods and procedures for ordering, storage, administration and disposal and record keeping of drugs and biologicals.
- Monthly drug regimen review reports.

The consultant's visits must be scheduled to be of sufficient duration and at a time convenient to:

- Work with nursing staff on the resident care plan.
- Consult with the administrator and others on developing and implementing policies and procedures.
- Plan in-service training and staff development for employees.

A facility that does not employ a licensed pharmacist must have formal arrangements with a licensed pharmacist. These arrangements must include separate written contracts for pharmaceutical vendor services and consultant pharmacist services.

The facility must provide reimbursement for consultant pharmacists based on fair market value. Documentation of consultation must be available for review in the facility.

F. Social Worker

A facility with more than l20 beds must employ a qualified social worker on a full-time basis. A qualified social worker is a person who meets both of the following criteria:

- A bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation, counseling, or psychology.
- One year of supervised social work experience in a health care setting working directly with people.

G. Activities Staff

The activities program must be directed by a qualified professional who meets one of the following criteria:

- Is a qualified therapeutic recreation specialist or an activities professional who is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on October 1, 1990, or
- Has two years of experience in a social or recreational program within the last five years, one of which was full time in a patient activities program in a health care setting, or
- Is a qualified occupational therapist or occupational therapy assistant, or
- Has completed a training course approved by the state.

V. PROVISION OF SERVICES

Residents must be admitted only under the order of a physician. The facility must accept only those residents whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. Admission of residents to the facility must be determined by:

- Assessment of the resident's medical, health, and social situation.
- Adequacy of physical facilities and equipment for meeting the needs of the resident in a safe and effective manner.
- Adequacy and suitability of the facility personnel and resources to provide the services.
- Comparative benefit of nursing care in relation to care by a hospital or a home health agency.

The facility must provide and each resident must receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Services must be provided in accordance with the resident's assessment and care plan.

The facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of the resident's individuality.

The following sections explain requirements for:

- Resident assessments.
- Screening and review for mental health and mental retardation service needs.
- Comprehensive care plans.
- Physician services.
- Nursing services.
- Dietary services.
- Pharmacy services.
- Social services and activities.
- Specialized rehabilitative services.
- Laboratory services.

- Radiology and other diagnostic services.
- Dental, vision, and hearing services.
- Quality assessment and assurance.

A. Resident Assessment (MDS)

Before admission you must conduct an assessment of each person seeking nursing facility placement. Gather assessment information similar to the data in the *Minimum Data Set* (MDS) resident assessment tool. The purpose of this assessment is:

- To identify those people who may be able to be served by home- and community-based services, and
- To provide education, assistance, or referral for these services.

Upon admission and periodically, you must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional ability. You must use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care.

Make a comprehensive assessment of a resident's needs based on the *Minimum Data Set* (MDS) specified by the Department of Inspections and Appeals. The assessment describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

Conduct assessments within 14 calendar days after admission or readmission, except for readmissions in which there is no significant change in the resident's physical or mental condition. Coordinate assessments with preadmission screening to the maximum extent practicable to avoid duplicative testing and effort.

Also complete assessments within 14 calendar days after there has been a significant change in the resident's physical or mental condition. Examine each resident no less than once every three months, and as appropriate, revise the resident's assessment to ensure the continued accuracy of the assessment. Always assess residents at least once every 12 months.

The comprehensive assessment must include at least the following:

- Identification and demographic information.
- Customary routine.
- Cognitive patterns.
- Communication.
- Vision.
- Mood and behavior patterns.
- Psychosocial well-being.
- Physical functioning and structural problems.
- Continence.

- Disease diagnoses and health conditions.
- Dental and nutritional status.
- Skin condition.
- Activity pursuit.
- Medications.
- Special treatments and procedures.
- Discharge potential.
- Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
- Documentation of participation in assessment.
- Additional specification relating to resident status as required in Section S of the MDS.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. Include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. A registered nurse must sign and certify that the assessment is completed.

A person who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment.

A person who willfully and knowingly causes another person to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.

If the Department determines that there has been a knowing and willful certification of false statements, the Department may require that resident assessments be conducted and certified by persons who are independent of the facility. (See Item X. F, **Requirement of Independent Assessors**, for more information.)

The following sections include:

- An explanation of the requirements for automated submission of the MDS.
- A facsimile of the MDS form, version 2.0.

1. Automated Data Processing Requirement

Within seven days after completing a resident's assessment, enter the resident's assessment information into a computerized format for transmission to the state. This format must:

- Conform to standard record layouts and data dictionaries.
- Pass edits that ensure accurate and consistent coding of the MDS data.

On at least a monthly basis, input and electronically transmit accurate and complete MDS data for all assessments conducted during the previous month. Transmit MDS data in the ASCII format specified by the Health Care Financing Administration. Include the following:

- Admission assessment.
- Annual assessment.
- Significant correction of prior full assessment.
- Significant correction of prior quarterly assessment.
- Quarterly review.
- A subset of items upon a resident's transfer, reentry, discharge, and death.
- Background (face sheet) information, for an initial transmission of MDS data on a resident who does not have an admission assessment.

Do not release information that is resident-identifiable to the public. Release information that is resident-identifiable to an agent only under a contract where the agent agrees not to use or disclose the information except to the extent the facility itself may do so.

2. Facsimile of MDS 2.0

Form *MDS*-Version 2.0 follows on pages 67-81. This form can also be downloaded from http://www.hcfa.gov

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ④	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	GENDER ④	1. Male 2. Female
3.	BIRTHDATE ④	Month — Day — Year
4.	RACE/ ④ ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY ④ AND MEDICARE NUMBERS ④ [C in 1st box if non med. no.]	**a.** Social Security Number **b.** Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ④	**a.** State No. **b.** Federal No.
7.	MEDICAID NO. *["+" if pending, "N" if not a Medicaid recipient]* ④	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] **a.** Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* **b.** ***Codes for assessments required for Medicare PPS or the State*** *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature and Title	Sections	Date
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			
l.			

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

④ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter **a.** = When letter in box, check if condition applies

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1. DATE OF ENTRY

Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date

Month — Day — Year

2. ADMITTED FROM (AT ENTRY)

1. Private home/apt. with no home health services
2. Private home/apt. with home health services
3. Board and care/assisted living/group home
4. Nursing home
5. Acute care hospital
6. Psychiatric hospital, MR/DD facility
7. Rehabilitation hospital
8. Other

3. LIVED ALONE (PRIOR TO ENTRY)

0. No
1. Yes
2. In other facility

4. ZIP CODE OF PRIOR PRIMARY RESIDENCE

5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY

(***Check all settings*** *resident* ***lived in*** *during 5 years prior to date of entry given in item AB1 above)*

- Prior stay at this nursing home — a.
- Stay in other nursing home — b.
- Other residential facility—board and care home, assisted living, group home — c.
- MH/psychiatric setting — d.
- MR/DD setting — e.
- *NONE OF ABOVE* — f.

6. LIFETIME OCCUPATION(S) [Put "/" between two occupations]

7. EDUCATION (*Highest Level Completed*)

1. No schooling
2. 8th grade/less
3. 9-11 grades
4. High school
5. Technical or trade school
6. Some college
7. Bachelor's degree
8. Graduate degree

8. LANGUAGE

(*Code for correct response*)

a. Primary Language

0. English 1. Spanish 2. French 3. Other

b. If other, specify

9. MENTAL HEALTH HISTORY

Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem?

0. No 1. Yes

10. CONDITIONS RELATED TO MR/DD STATUS

(***Check all conditions*** *that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely*)

- Not applicable—no MR/DD (Skip to AB11) — a.
- MR/DD with organic condition
  - Down's syndrome — b.
  - Autism — c.
  - Epilepsy — d.
  - Other organic condition related to MR/DD — e.
- MR/DD with no organic condition — f.

11. DATE BACKGROUND INFORMATION COMPLETED

Month — Day — Year

SECTION AC. CUSTOMARY ROUTINE

1. CUSTOMARY ROUTINE (*In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home*)

(***Check all that apply.*** *If all information UNKNOWN, check last box only.*)

CYCLE OF DAILY EVENTS

- Stays up late at night (e.g., after 9 pm) — a.
- Naps regularly during day (at least 1 hour) — b.
- Goes out 1+ days a week — c.
- Stays busy with hobbies, reading, or fixed daily routine — d.
- Spends most of time alone or watching TV — e.
- Moves independently indoors (with appliances, if used) — f.
- Use of tobacco products at least daily — g.
- *NONE OF ABOVE* — h.

EATING PATTERNS

- Distinct food preferences — i.
- Eats between meals all or most days — j.
- Use of alcoholic beverage(s) at least weekly — k.
- *NONE OF ABOVE* — l.

ADL PATTERNS

- In bedclothes much of day — m.
- Wakens to toilet all or most nights — n.
- Has irregular bowel movement pattern — o.
- Showers for bathing — p.
- Bathing in PM — q.
- *NONE OF ABOVE* — r.

INVOLVEMENT PATTERNS

- Daily contact with relatives/close friends — s.
- Usually attends church, temple, synagogue (etc.) — t.
- Finds strength in faith — u.
- Daily animal companion/presence — v.
- Involved in group activities — w.
- *NONE OF ABOVE* — x.
- **UNKNOWN**—Resident/family unable to provide information — y.

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:

a. Signature of RN Assessment Coordinator — Date

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature and Title	Sections	Date
b.			
c.			
d.			
e.			
f.			
g.			

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME

a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)

2. ROOM NUMBER

3. ASSESSMENT REFERENCE DATE

a. *Last day of MDS observation period*

Month — Day — Year

b. Original (0) or corrected copy of form (enter number of correction)

4a. DATE OF REENTRY

Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)

Month — Day — Year

5. MARITAL STATUS

1. Never married
2. Married
3. Widowed
4. Separated
5. Divorced

6. MEDICAL RECORD NO.

7. CURRENT PAYMENT SOURCES FOR N.H. STAY

(*Billing Office to indicate;* ***check all that apply in last 30 days***)

Medicaid per diem	a.	VA per diem	f.
Medicare per diem	b.	Self or family pays for full per diem	g.
Medicare ancillary part A	c.	Medicaid resident liability or Medicare co-payment	h.
Medicare ancillary part B	d.	Private insurance per diem (including co-payment)	i.
CHAMPUS per diem	e.	Other per diem	j.

8. REASONS FOR ASSESSMENT

[Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed]

a. Primary reason for assessment

1. Admission assessment (required by day 14)
2. Annual assessment
3. Significant change in status assessment
4. Significant correction of prior full assessment
5. Quarterly review assessment
6. Discharged—return not anticipated
7. Discharged—return anticipated
8. Discharged prior to completing initial assessment
9. Reentry
10. Significant correction of prior quarterly assessment
0. *NONE OF ABOVE*

b. ***Codes for assessments required for Medicare PPS or the State***

1. *Medicare 5 day assessment*
2. *Medicare 30 day assessment*
3. *Medicare 60 day assessment*
4. *Medicare 90 day assessment*
5. *Medicare readmission/return assessment*
6. *Other state required assessment*
7. *Medicare 14 day assessment*
8. *Other Medicare required assessment*

9. RESPONSIBILITY/ LEGAL GUARDIAN

(***Check all that apply***)

Legal guardian	a.	Durable power attorney/financial	d.
Other legal oversight	b.	Family member responsible	e.
Durable power of attorney/health care	c.	Patient responsible for self	f.
		NONE OF ABOVE	g.

10. ADVANCED DIRECTIVES

(*For those items with supporting* ***documentation*** *in the medical record,* ***check all that apply***)

Living will	a.	Feeding restrictions	f.
Do not resuscitate	b.	Medication restrictions	g.
Do not hospitalize	c.	Other treatment restrictions	h.
Organ donation	d.		
Autopsy request	e.	*NONE OF ABOVE*	i.

SECTION B. COGNITIVE PATTERNS

1. COMATOSE

(*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (**If yes, skip to Section G**)

2. MEMORY

(*Recall of what was learned or known*)

a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem

b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

3. MEMORY/ RECALL ABILITY

(***Check all*** *that resident was* ***normally able to recall during last 7 days***)

Current season	a.	That he/she is in a nursing home	d.
Location of own room	b.		
Staff names/faces	c.	*NONE OF ABOVE* are recalled	e.

4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING

(*Made decisions regarding tasks of daily life*)

0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS

(*Code for behavior in the* ***last 7 days.)*** ***[Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time]***.

0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)

b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)

d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)

e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)

f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

6. CHANGE IN COGNITIVE STATUS

Resident's cognitive status, skills, or abilities have changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING

(*With hearing appliance, if used*)

0. *HEARS ADEQUATELY*—normal talk, TV, phone
1. *MINIMAL DIFFICULTY* when not in quiet setting
2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly
3. *HIGHLY IMPAIRED*/absence of useful hearing

2. COMMUNICATION DEVICES/ TECHNIQUES

(***Check all that apply*** *during last 7 days*)

Hearing aid, present and used	a.
Hearing aid, present and not used regularly	b.
Other receptive comm. techniques used (e.g., lip reading)	c.
NONE OF ABOVE	d.

3. MODES OF EXPRESSION

(***Check all used*** *by resident to make needs known*)

Speech	a.	Signs/gestures/sounds	d.
Writing messages to express or clarify needs	b.	Communication board	e.
		Other	f.
American sign language or Braille	c.	*NONE OF ABOVE*	g.

4. MAKING SELF UNDERSTOOD

(*Expressing information content—however able*)

0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

5. SPEECH CLARITY

(*Code for speech in the* ***last 7 days***)

0. *CLEAR SPEECH*—distinct, intelligible words
1. *UNCLEAR SPEECH*—slurred, mumbled words
2. *NO SPEECH*—absence of spoken words

6. ABILITY TO UNDERSTAND OTHERS

(*Understanding verbal information content—however able*)

0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

7. CHANGE IN COMMUNICATION/ HEARING

Resident's ability to express, understand, or hear information has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

Resident _____ Numeric Identifier _____

SECTION D. VISION PATTERNS

1.	VISION	(*Ability to see in adequate light and with glasses if used*) 0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books 1. *IMPAIRED*—sees large print, but not regular print in newspapers/ books 2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)	a.
		Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes	b.
		NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

(***Code for indicators observed in last 30 days, irrespective of the assumed cause***)
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS

a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"

b. Repetitive questions—e.g., "*Where do I go; What do I do?*"

c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")

d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received

e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"

f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others

g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack

h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES

j. Unpleasant mood in morning

k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE

l. Sad, pained, worried facial expressions—e.g., furrowed brows

m. Crying, tearfulness

n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST

o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends

p. Reduced social interaction

2. MOOD PERSISTENCE

One or more indicators of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days**
0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered

3. CHANGE IN MOOD

Resident's mood status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

4. BEHAVIORAL SYMPTOMS

(A) ***Behavioral*** *symptom* ***frequency in last 7 days***
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) ***Behavioral*** *symptom* ***alterability in last 7 days***
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)		

5. CHANGE IN BEHAVIORAL SYMPTOMS

Resident's behavior status has changed as compared to **status of 90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED RELATIONSHIPS	Covert/open conflict with or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(***Code*** *for resident's* ***PERFORMANCE OVER ALL SHIFTS during last 7 days****—Not including setup*)

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
—Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(***Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless*** *of resident's self-performance classification*)

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

Resident _____ Numeric Identifier _____

2.	**BATHING**	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) ***Code for most dependent*** *in self-performance and support.* **(A)** BATHING SELF-PERFORMANCE codes appear below 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during entire 7 days (*Bathing support codes are as defined in* ***Item 1, code B above***)	(A)	(B)
3.	**TEST FOR BALANCE** **(see training manual)**	(*Code for ability during test in the* ***last 7 days***) 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help **a.** Balance while standing **b.** Balance while sitting—position, trunk control		
4.	**FUNCTIONAL LIMITATION IN RANGE OF MOTION** **(see training manual)**	(*Code for limitations during* ***last 7 days*** *that interfered with daily functions or placed resident at risk of injury*) **(A)** *RANGE OF MOTION* 0. No limitation 1. Limitation on one side 2. Limitation on both sides **(B)** *VOLUNTARY MOVEMENT* 0. No loss 1. Partial loss 2. Full loss **a.** Neck **b.** Arm—Including shoulder or elbow **c.** Hand—Including wrist or fingers **d.** Leg—Including hip or knee **e.** Foot—Including ankle or toes **f.** Other limitation or loss	(A)	(B)
5.	**MODES OF LOCOMOTION**	(***Check all that apply*** *during* ***last 7 days***) Cane/walker/crutch **a.** Wheeled self **b.** Other person wheeled **c.** Wheelchair primary mode of locomotion **d.** *NONE OF ABOVE* **e.**		
6.	**MODES OF TRANSFER**	(***Check all that apply*** *during* ***last 7 days***) Bedfast all or most of time **a.** Bed rails used for bed mobility or transfer **b.** Lifted manually **c.** Lifted mechanically **d.** Transfer aid (e.g., slide board, trapeze, cane, walker, brace) **e.** *NONE OF ABOVE* **f.**		
7.	**TASK SEGMENTATION**	Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them 0. No 1. Yes		
8.	**ADL FUNCTIONAL REHABILITATION POTENTIAL**	Resident believes he/she is capable of increased independence in at least some ADLs **a.** Direct care staff believe resident is capable of increased independence in at least some ADLs **b.** Resident able to perform tasks/activity but is very slow **c.** Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings **d.** *NONE OF ABOVE* **e.**		
9.	**CHANGE IN ADL FUNCTION**	Resident's ADL self-performance status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

SECTION H. CONTINENCE IN LAST 14 DAYS

1.	CONTINENCE SELF-CONTROL CATEGORIES (***Code for resident's PERFORMANCE OVER ALL SHIFTS***) 0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]* 1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week 3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week 4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time
a.	**BOWEL CONTINENCE** Control of bowel movement, with appliance or bowel continence programs, if employed
b.	**BLADDER CONTINENCE** Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed
2.	**BOWEL ELIMINATION PATTERN** Bowel elimination pattern regular—at least one movement every three days **a.** Constipation **b.** Diarrhea **c.** Fecal impaction **d.** *NONE OF ABOVE* **e.**

3.	**APPLIANCES AND PROGRAMS**	Any scheduled toileting plan **a.** Bladder retraining program **b.** External (condom) catheter **c.** Indwelling catheter **d.** Intermittent catheter **e.** Did not use toilet room/ commode/urinal **f.** Pads/briefs used **g.** Enemas/irrigation **h.** Ostomy present **i.** *NONE OF ABOVE* **j.**		
4.	**CHANGE IN URINARY CONTINENCE**	Resident's urinary continence has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1.	**DISEASES**	(***If none apply, CHECK the NONE OF ABOVE box***) **ENDOCRINE/METABOLIC/ NUTRITIONAL** Diabetes mellitus **a.** Hyperthyroidism **b.** Hypothyroidism **c.** **HEART/CIRCULATION** Arteriosclerotic heart disease (ASHD) **d.** Cardiac dysrhythmias **e.** Congestive heart failure **f.** Deep vein thrombosis **g.** Hypertension **h.** Hypotension **i.** Peripheral vascular disease **j.** Other cardiovascular disease **k.** **MUSCULOSKELETAL** Arthritis **l.** Hip fracture **m.** Missing limb (e.g., amputation) **n.** Osteoporosis **o.** Pathological bone fracture **p.** **NEUROLOGICAL** Alzheimer's disease **q.** Aphasia **r.** Cerebral palsy **s.** Cerebrovascular accident (stroke) **t.** Dementia other than Alzheimer's disease **u.** Hemiplegia/Hemiparesis **v.** Multiple sclerosis **w.** Paraplegia **x.** Parkinson's disease **y.** Quadriplegia **z.** Seizure disorder **aa.** Transient ischemic attack (TIA) **bb.** Traumatic brain injury **cc.** **PSYCHIATRIC/MOOD** Anxiety disorder **dd.** Depression **ee.** Manic depression (bipolar disease) **ff.** Schizophrenia **gg.** **PULMONARY** Asthma **hh.** Emphysema/COPD **ii.** **SENSORY** Cataracts **jj.** Diabetic retinopathy **kk.** Glaucoma **ll.** Macular degeneration **mm.** **OTHER** Allergies **nn.** Anemia **oo.** Cancer **pp.** Renal failure **qq.** *NONE OF ABOVE* **rr.**
2.	**INFECTIONS**	(***If none apply, CHECK the NONE OF ABOVE box***) Antibiotic resistant infection (e.g., Methicillin resistant staph) **a.** Clostridium difficile (c. diff.) **b.** Conjunctivitis **c.** HIV infection **d.** Pneumonia **e.** Respiratory infection **f.** Septicemia **g.** Sexually transmitted diseases **h.** Tuberculosis **i.** Urinary tract infection **in last 30 days** **j.** Viral hepatitis **k.** Wound infection **l.** NONE OF ABOVE **m.**
3.	**OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES**	a. _____		
		b. _____		
		c. _____		
		d. _____		
		e. _____		

SECTION J. HEALTH CONDITIONS

1.	**PROBLEM CONDITIONS**	(***Check all problems present*** *in* ***last 7 days*** *unless other time frame is indicated*) **INDICATORS OF FLUID STATUS** Weight gain or loss of 3 or more pounds within a 7 day period **a.** Inability to lie flat due to shortness of breath **b.** Dehydrated; output exceeds input **c.** Insufficient fluid; did **NOT** consume all/almost all liquids provided during **last 3 days** **d.** **OTHER** Delusions **e.** Dizziness/Vertigo **f.** Edema **g.** Fever **h.** Hallucinations **i.** Internal bleeding **j.** Recurrent lung aspirations in **last 90 days** **k.** Shortness of breath **l.** Syncope (fainting) **m.** Unsteady gait **n.** Vomiting **o.** *NONE OF ABOVE* **p.**

Resident _____ Numeric Identifier _____

2.	**PAIN SYMPTOMS**	(*Code the **highest level of pain** present in the **last 7 days***)	
		a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (***skip to J4***) 1. Pain less than daily 2. Pain daily	**b. INTENSITY** of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating
3.	**PAIN SITE**	(*If pain present, **check all sites** that apply in **last 7 days***)	
		Back pain **a.** Bone pain **b.** Chest pain while doing usual activities **c.** Headache **d.** Hip pain **e.**	Incisional pain **f.** Joint pain (other than hip) **g.** Soft tissue pain (e.g., lesion, muscle) **h.** Stomach pain **i.** Other **j.**
4.	**ACCIDENTS**	(***Check all that apply***)	
		Fell in **past 30 days** **a.** Fell in **past 31-180 days** **b.**	Hip fracture in **last 180 days** **c.** Other fracture in **last 180 days** **d.** *NONE OF ABOVE* **e.**
5.	**STABILITY OF CONDITIONS**	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating) **a.** Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem **b.** End-stage disease, 6 or fewer months to live **c.** *NONE OF ABOVE* **d.**	

SECTION K. ORAL/NUTRITIONAL STATUS

1.	**ORAL PROBLEMS**	Chewing problem **a.** Swallowing problem **b.** Mouth pain **c.** *NONE OF ABOVE* **d.**	
2.	**HEIGHT AND WEIGHT**	*Record **(a.) height in inches** and **(b.) weight in pounds**. Base weight on most recent measure in **last 30 days**; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes* **a.** HT (in.) ☐☐ **b.** WT (lb.) ☐☐☐	
3.	**WEIGHT CHANGE**	**a. Weight loss**—5 % or more in **last 30 days**; or 10 % or more in **last 180 days** 0. No 1. Yes **b. Weight gain**—5 % or more in **last 30 days**; or 10 % or more in **last 180 days** 0. No 1. Yes	
4.	**NUTRITIONAL PROBLEMS**	Complains about the taste of many foods **a.** Regular or repetitive complaints of hunger **b.**	Leaves 25% or more of food uneaten at most meals **c.** *NONE OF ABOVE* **d.**
5.	**NUTRITIONAL APPROACHES**	(***Check all that apply in last 7 days***)	
		Parenteral/IV **a.** Feeding tube **b.** Mechanically altered diet **c.** Syringe (oral feeding) **d.** Therapeutic diet **e.**	Dietary supplement between meals **f.** Plate guard, stabilized built-up utensil, etc. **g.** On a planned weight change program **h.** *NONE OF ABOVE* **i.**
6.	**PARENTERAL OR ENTERAL INTAKE**	(***Skip to Section L if neither 5a nor 5b is checked***) **a.** Code the proportion of **total calories** the resident received through parenteral or tube feedings in the **last 7 days** 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50% **b.** Code the average **fluid intake** per day by IV or tube in **last 7 days** 0. None 3. 1001 to 1500 cc/day 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day	

SECTION L. ORAL/DENTAL STATUS

1.	**ORAL STATUS AND DISEASE PREVENTION**	Debris (soft, easily movable substances) present in mouth prior to going to bed at night **a.** Has dentures or removable bridge **b.** Some/all natural teeth lost—does not have or does not use dentures (or partial plates) **c.** Broken, loose, or carious teeth **d.** Inflamed gums (gingiva); swollen or bleeding gums; oral abcesses; ulcers or rashes **e.** Daily cleaning of teeth/dentures or daily mouth care—by resident or staff **f.** *NONE OF ABOVE* **g.**	

SECTION M. SKIN CONDITION

1.	**ULCERS (Due to any cause)**	*(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9 = 9 or more.)* ***[Requires full body exam.]***	**Number at Stage**
		a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
2.	**TYPE OF ULCER**	(*For each type of ulcer, **code for the highest stage in the last 7 days** using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4*)	
		a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue	
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
3.	**HISTORY OF RESOLVED ULCERS**	Resident had an ulcer that was resolved or cured **in LAST 90 DAYS** 0. No 1. Yes	
4.	**OTHER SKIN PROBLEMS OR LESIONS PRESENT**	(***Check all that apply** during **last 7 days***)	
		Abrasions, bruises **a.** Burns (second or third degree) **b.** Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) **c.** Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster **d.** Skin desensitized to pain or pressure **e.** Skin tears or cuts (other than surgery) **f.** Surgical wounds **g.** *NONE OF ABOVE* **h.**	
5.	**SKIN TREATMENTS**	(***Check all that apply** during **last 7 days)***	
		Pressure relieving device(s) for chair **a.** Pressure relieving device(s) for bed **b.** Turning/repositioning program **c.** Nutrition or hydration intervention to manage skin problems **d.** Ulcer care **e.** Surgical wound care **f.** Application of dressings (with or without topical medications) other than to feet **g.** Application of ointments/medications (other than to feet) **h.** Other preventative or protective skin care (other than to feet) **i.** *NONE OF ABOVE* **j.**	
6.	**FOOT PROBLEMS AND CARE**	(***Check all that apply** during **last 7 days)***	
		Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems **a.** Infection of the foot—e.g., cellulitis, purulent drainage **b.** Open lesions on the foot **c.** Nails/calluses trimmed during **last 90 days** **d.** Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) **e.** Application of dressings (with or without topical medications) **f.** *NONE OF ABOVE* **g.**	

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	**TIME AWAKE**	(***Check appropriate time periods over last 7 days***) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:	
		Morning **a.** Afternoon **b.**	Evening **c.** *NONE OF ABOVE* **d.**
(If resident is comatose, skip to Section O)			
2.	**AVERAGE TIME INVOLVED IN ACTIVITIES**	(**When awake and not receiving treatments or ADL care**) 0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None	
3.	**PREFERRED ACTIVITY SETTINGS**	(***Check all settings** in which activities are **preferred***)	
		Own room **a.** Day/activity room **b.** Inside NH/off unit **c.**	Outside facility **d.** *NONE OF ABOVE* **e.**
4.	**GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)**	(***Check all PREFERENCES** whether or not activity is currently available to resident*)	
		Cards/other games **a.** Crafts/arts **b.** Exercise/sports **c.** Music **d.** Reading/writing **e.** Spiritual/religious activities **f.**	Trips/shopping **g.** Walking/wheeling outdoors **h.** Watching TV **i.** Gardening or plants **j.** Talking or conversing **k.** Helping others **l.** *NONE OF ABOVE* **m.**

Resident _____ Numeric Identifier _____

5. PREFERS CHANGE IN DAILY ROUTINE

Code for resident preferences in daily routines
0. No change 1. Slight change 2. Major change

- **a.** Type of activities in which resident is currently involved
- **b.** Extent of resident involvement in activities

SECTION O. MEDICATIONS

1. NUMBER OF MEDICATIONS (***Record the number of different*** *medications used in the* ***last 7 days****; enter "0" if none used*)

2. NEW MEDICATIONS (*Resident currently receiving medications that were initiated during the* ***last 90 days***)
0. No 1. Yes

3. INJECTIONS (***Record the number of DAYS*** *injections of any type received during the* ***last 7 days****; enter "0" if none used*)

4. DAYS RECEIVED THE FOLLOWING MEDICATION (***Record the number of DAYS*** *during* ***last 7 days****; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)

- **a.** Antipsychotic
- **b.** Antianxiety
- **c.** Antidepressant
- **d.** Hypnotic
- **e.** Diuretic

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

a. SPECIAL CARE—***Check*** *treatments or programs received during the* ***last 14 days***

TREATMENTS
- Chemotherapy — a.
- Dialysis — b.
- IV medication — c.
- Intake/output — d.
- Monitoring acute medical condition — e.
- Ostomy care — f.
- Oxygen therapy — g.
- Radiation — h.
- Suctioning — i.
- Tracheostomy care — j.
- Transfusions — k.
- Ventilator or respirator — l.

PROGRAMS
- Alcohol/drug treatment program — m.
- Alzheimer's/dementia special care unit — n.
- Hospice care — o.
- Pediatric unit — p.
- Respite care — q.
- Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) — r.
- *NONE OF ABOVE* — s.

b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the* ***last 7 calendar days*** *(Enter 0 if none or less than 15 min. daily)*
[Note—count only post admission therapies]
(A) = # of days administered for **15 minutes or more**
(B) = total # of minutes provided in **last 7 days**

	DAYS (A)	MIN (B)
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS (**Check all interventions or strategies used in last 7 days**—no matter where received)

- Special behavior symptom evaluation program — a.
- Evaluation by a licensed mental health specialist in **last 90 days** — b.
- Group therapy — c.
- Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage — d.
- Reorientation—e.g., cueing — e.
- *NONE OF ABOVE* — f.

3. NURSING REHABILITATION/ RESTORATIVE CARE *Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was* ***provided to the resident for more than or equal to 15 minutes per day in the last 7 days*** *(Enter 0 if none or less than 15 min. daily.)*

- **a.** Range of motion (passive)
- **b.** Range of motion (active)
- **c.** Splint or brace assistance
- **TRAINING AND SKILL PRACTICE IN:**
- **d.** Bed mobility
- **e.** Transfer
- **f.** Walking
- **g.** Dressing or grooming
- **h.** Eating or swallowing
- **i.** Amputation/prosthesis care
- **j.** Communication
- **k.** Other

4. DEVICES AND RESTRAINTS (*Use the following codes for* ***last 7 days***:)
0. Not used
1. Used less than daily
2. Used daily

Bed rails
- **a.** — Full bed rails on all open sides of bed
- **b.** — Other types of side rails used (e.g., half rail, one side)
- **c.** Trunk restraint
- **d.** Limb restraint
- **e.** Chair prevents rising

5. HOSPITAL STAY(S) Record number of times resident was admitted to hospital with an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no hospital admissions*)

6. EMERGENCY ROOM (ER) VISIT(S) Record number of times resident visited ER without an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no ER visits*)

7. PHYSICIAN VISITS In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)

8. PHYSICIAN ORDERS In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* (*Enter 0 if none*)

9. ABNORMAL LAB VALUES Has the resident had any abnormal lab values during the **last 90 days** (or since admission)?
0. No 1. Yes

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1. DISCHARGE POTENTIAL

a. Resident expresses/indicates preference to return to the community
0. No 1. Yes

b. Resident has a support person who is positive towards discharge
0. No 1. Yes

c. Stay projected to be of a short duration— discharge projected **within 90 days** (do not include expected discharge due to death)
0. No 2. Within 31-90 days
1. Within 30 days 3. Discharge status uncertain

2. OVERALL CHANGE IN CARE NEEDS Resident's overall self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support

SECTION R. ASSESSMENT INFORMATION

1. PARTICIPATION IN ASSESSMENT

a. Resident:	0. No	1. Yes	
b. Family:	0. No	1. Yes	2. No family
c. Significant other:	0. No	1. Yes	2. None

2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete — Month / Day / Year

Resident _____ Numeric Identifier _____

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1. SPECIAL TREATMENTS AND PROCEDURES

a. RECREATION THERAPY—*Enter number of days and total minutes of recreation therapy administered* (***for at least 15 minutes a day***) *in the* ***last 7 days*** (*Enter 0 if none*)

(A) = # of days administered for 15 minutes or more
(B) = total # of minutes provided in last 7 days

DAYS	MIN
(A)	(B)

Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.

b. ORDERED THERAPIES—*Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service*?
0. No 1. Yes

If not ordered, skip to item 2

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?

2. WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:

- Resident received physical therapy involving gait training (P.1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.1.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

(***FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.***)

a. Furthest distance walked without sitting down during this episode.

0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. Time walked without sitting down during this episode.

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. Self-Performance in walking during this episode.

0. *INDEPENDENT*—No help or oversight
1. *SUPERVISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*—Resident received weight bearing assistance while walking

d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. Parallel bars used by resident in association with this episode.

0. No 1. Yes

3. CASE MIX GROUP

Medicare _____ **State** _____

Numeric Identifier _____

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Resident's Name:	Medical Record No.:

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
   - Describe:
     — Nature of the condition (may include presence or lack of objective data and subjective complaints).
     — Complications and risk factors that affect your decision to proceed to care planning.
     — Factors that must be considered in developing individualized care plan interventions.
     — Need for referrals/further evaluation by appropriate health professionals.
   - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
   - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

A. RAP PROBLEM AREA	(a) Check if triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM	☐		☐
2. COGNITIVE LOSS	☐		☐
3. VISUAL FUNCTION	☐		☐
4. COMMUNICATION	☐		☐
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL	☐		☐
6. URINARY INCONTINENCE AND INDWELLING CATHETER	☐		☐
7. PSYCHOSOCIAL WELL-BEING	☐		☐
8. MOOD STATE	☐		☐
9. BEHAVIORAL SYMPTOMS	☐		☐
10. ACTIVITIES	☐		☐
11. FALLS	☐		☐
12. NUTRITIONAL STATUS	☐		☐
13. FEEDING TUBES	☐		☐
14. DEHYDRATION/FLUID MAINTENANCE	☐		☐
15. DENTAL CARE	☐		☐
16. PRESSURE ULCERS	☐		☐
17. PSYCHOTROPIC DRUG USE	☐		☐
18. PHYSICAL RESTRAINTS	☐		☐

B. _____

1. Signature of RN Coordinator for RAP Assessment Process

2. ☐☐ — ☐☐ — ☐☐☐☐ (Month — Day — Year)

_____

3. Signature of Person Completing Care Planning Decision

4. ☐☐ — ☐☐ — ☐☐☐☐ (Month — Day — Year)

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Key:

- ● = One item required to trigger
- ❷ = Two items required to trigger
- ✱ = One of these three items, plus at least one other item required to trigger
- ⓐ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A @	ADL-Maintenance Trigger B @	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	
B2a	Short term memory	1		●																			B2a
B2b	Long term memory	1		●																			B2b
B4	Decision making	1,2,3		●																			B4
B4	Decision making	3					●																B4
B5a to B5f	Indicators of delirium	2	●																	●			B5a to B5f
B6	Change in cognitive status	2	●																	●			B6
C1	Hearing	1,2,3				●																	C1
C4	Understood by others	1,2,3				●																	C4
C6	Understand others	1,2,3		●		●																	C6
C7	Change in communication	2																		●			C7
D1	Vision	1,2,3			●																		D1
D2a	Side vision problem	✓			●																		D2a
E1a to E1p	Indicators of depression, anxiety, sad mood	1,2									●												E1a to E1p
E1n	Repetitive movement	1,2																		●			E1n
E1o	Withdrawal from activities	1,2								●													E1o
E2	Mood persistence	1,2									●												E2
E3	Change in Mood	2	●																	●			E3
E4aA	Wandering	1,2,3													●								E4aA
E4aA - E4eA	Behavioral symptoms	1,2,3										●											E4aA - E4eA
E5	Change in behavioral symptoms	1										●											E5
E5	Change in behavioral symptoms	2	●																	●			E5
F1d	Establishes own goals	✓								●													F1d
F2a to F2d	Unsettled relationships	✓								●													F2a to F2d
F3a	Strong id. past roles	✓								●													F3a
F3b	Lost roles	✓								●													F3b
F3c	Daily routine different	✓								●													F3c
G1aA - G1jA	ADL self-performance	1,2,3,4					●																G1aA - G1jA
G1aA	Bed mobility	2,3,4,8																	●				G1aA
G2A	Bathing	1,2,3,4					●																G2A
G3b	Balance while sitting	1,2,3																		●			G3b
G6a	Bedfast	✓																	●				G6a
G8a,b	Resident, staff believe capable	✓					●																G8a,b
H1a	Bowel incontinence	1,2,3,4																	●				H1a
H1b	Bladder incontinence	2,3,4						●															H1b
H2b	Constipation	✓																		●			H2b
H2d	Fecal impaction	✓																		●			H2d
H3c,d,e	Catheter use	✓						●															H3c,d,e
H3g	Use of pads/briefs	✓						●															H3g
I1i	Hypotension	✓																		●			I1i
I1j	Peripheral vascular disease	✓																	●				I1j
I1ee	Depression	✓																		●			I1ee
I1jj	Cataracts	✓			●																		I1jj
I1ll	Glaucoma	✓			●																		I1ll
I2j	UTI	✓															●						I2j
I3	Dehydration diagnosis	276.5															●						I3
J1a	Weight fluctuation	✓															●						J1a
J1c	Dehydrated	✓															●						J1c
J1d	Insufficient fluid	✓															●						J1d
J1f	Dizziness	✓													●					●			J1f
J1h	Fever	✓															●						J1h
J1i	Hallucinations	✓																		●			J1i
J1j	Internal bleeding	✓															●						J1j
J1k	Lung aspirations	✓																		●			J1k
J1m	Syncope	✓																		●			J1m

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Key:

- ● = One item required to trigger
- ❷ = Two items required to trigger
- ✱ = One of these three items, plus at least one other item required to trigger
- ⓐ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A ⓐ	ADL-Maintenance Trigger B ⓐ	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	
J1n	Unsteady gait	✓																		●			J1n
J4a,b	Fell	✓													●					●			J4a,b
J4c	Hip fracture	✓																		●			J4c
K1b	Swallowing problem	✓																		●			K1b
K1c	Mouth pain	✓																●					K1c
K3a	Weight loss	1														●							K3a
K4a	Taste alteration	✓														●							K4a
K4c	Leave 25% food	✓														●							K4c
K5a	Parenteral/IV feeding	✓														●		●					K5a
K5b	Feeding tube	✓															●	●					K5b
K5c	Mechanically altered	✓														●							K5c
K5d	Syringe feeding	✓														●							K5d
K5e	Therapeutic diet	✓														●							K5e
L1a,c,d,e	Dental	✓																	●				L1a,c,d,e
L1f	Daily cleaning teeth	Not ✓																	●				L1f
M2a	Pressure ulcer	2,3,4														●							M2a
M2a	Pressure ulcer	1,2,3,4																	●				M2a
M3	Previous pressure ulcer	1																	●				M3
M4e	Impaired tactile sense	✓																	●				M4e
N1a	Awake morning	✓											❷										N1a
N2	Involved in activities	0											❷										N2
N2	Involved in activities	2,3										●											N2
N5a,b	Prefers change in daily routine	1,2										●											N5a,b
O4a	Antipsychotics	1-7																		✱			O4a
O4b	Antianxiety	1-7													●					✱			O4b
O4c	Antidepressants	1-7													●					✱			O4c
O4e	Diuretic	1-7																●					O4e
P4c	Trunk restraint	1,2													●						●		P4c
P4c	Trunk restraint	2																	●				P4c
P4d	Limb restraint	1,2																			●		P4d
P4e	Chair prevents rising	1,2																			●		P4e

MDS QUARTERLY ASSESSMENT FORM

Numeric Identifier _____

A1. RESIDENT NAME

a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)

A2. ROOM NUMBER

A3. ASSESSMENT REFERENCE DATE

a. Last day of MDS observation period

Month — Day — Year

b. Original (0) or corrected copy of form (enter number of correction)

A4a. DATE OF REENTRY

Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)

Month — Day — Year

A6. MEDICAL RECORD NO.

B1. COMATOSE

(*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (***Skip to Section G***)

B2. MEMORY

(*Recall of what was learned or known*)

a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem

b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING

(*Made decisions regarding tasks of daily life*)

0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS

(*Code for behavior in the* ***last 7 days.)*** **[*Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time*].**

0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)

b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)

d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)

e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)

f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

C4. MAKING SELF UNDERSTOOD

(*Expressing information content—however able*)

0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

C6. ABILITY TO UNDERSTAND OTHERS

(*Understanding verbal information content—however able*)

0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. S*OMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

(***Code for indicators observed in last 30 days, irrespective of the assumed cause***)

0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS

a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"

b. Repetitive questions—e.g., "*Where do I go; What do I do?*"

c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")

d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received

e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (cont.)

VERBAL EXPRESSIONS OF DISTRESS

f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others

g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack

h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES

j. Unpleasant mood in morning

k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE

l. Sad, pained, worried facial expressions—e.g., furrowed brows

m. Crying, tearfulness

n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST

o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends

p. Reduced social interaction

E2. MOOD PERSISTENCE

One or more indicators of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days**

0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered

E4. BEHAVIORAL SYMPTOMS

(A) *Behavioral* *symptom* *frequency in last 7 days*

0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) *Behavioral* *symptom* *alterability in last 7 days*

0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)		

G1. (A) ADL SELF-PERFORMANCE—(***Code*** *for resident's* ***PERFORMANCE OVER ALL SHIFTS during last 7 days****—Not including setup*)

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

			(A)
a.	**BED MOBILITY**	How resident moves to and from lying position, turns side to side, and positions body while in bed	
b.	**TRANSFER**	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	
c.	**WALK IN ROOM**	How resident walks between locations in his/her room.	
d.	**WALK IN CORRIDOR**	How resident walks in corridor on unit.	
e.	**LOCOMOTION ON UNIT**	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	
f.	**LOCOMOTION OFF UNIT**	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	
g.	**DRESSING**	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis	
h.	**EATING**	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).	

Resident_____ Numeric Identifier _____

i. TOILET USE — How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes

j. PERSONAL HYGIENE — How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)

G2. BATHING — How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.)
Code for most dependent *in self-performance.*
(A) BATHING SELF PERFORMANCE codes appear below

(A)

0. Independent—No help provided
1. Supervision—Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence
8. Activity itself did not occur during entire 7 days

G4. FUNCTIONAL LIMITATION IN RANGE OF MOTION — (*Code for limitations during* ***last 7 days*** *that interfered with daily functions or placed residents at risk of injury*)

(A) *RANGE OF MOTION*: 0. No limitation; 1. Limitation on one side; 2. Limitation on both sides
(B) *VOLUNTARY MOVEMENT*: 0. No loss; 1. Partial loss; 2. Full loss

	(A)	(B)
a. Neck		
b. Arm—Including shoulder or elbow		
c. Hand—Including wrist or fingers		
d. Leg—Including hip or knee		
e. Foot—Including ankle or toes		
f. Other limitation or loss		

G6. MODES OF TRANSFER — (***Check all that apply*** *during* ***last 7 days***)

Bedfast all or most of time **a.** | Bed rails used for bed mobility or transfer **b.** | *NONE OF ABOVE* **f.**

H1. CONTINENCE SELF-CONTROL CATEGORIES
(***Code for resident's PERFORMANCE OVER ALL SHIFTS***)

0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*
1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a. BOWEL CONTINENCE — Control of bowel movement, with appliance or bowel continence programs, if employed

b. BLADDER CONTINENCE — Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed

H2. BOWEL ELIMINATION PATTERN — Fecal impaction **d.** | *NONE OF ABOVE* **e.**

H3. APPLIANCES AND PROGRAMS

Any scheduled toileting plan	**a.**	Indwelling catheter	**d.**
Bladder retraining program	**b.**	Ostomy present	**i.**
External (condom) catheter	**c.**	*NONE OF ABOVE*	**j.**

I2. INFECTIONS — Urinary tract infection **in last 30 days** **j.** | *NONE OF ABOVE* **m.**

I3. OTHER CURRENT DIAGNOSES AND ICD-9 CODES — (*Include* ***only those diseases diagnosed in the last 90 days that have a relationship*** *to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death*)

a. _____ | | | | • | |
b. _____ | | | | • | |

J1. PROBLEM CONDITIONS — (***Check all problems present*** *in* ***last 7 days***)

Dehydrated; output exceeds input **c.** | Hallucinations **i.** | *NONE OF ABOVE* **p.**

J2. PAIN SYMPTOMS — (*Code the* ***highest level of pain*** *present in the* ***last 7 days***)

a. FREQUENCY with which resident complains or shows evidence of pain
0. No pain (***skip to J4***)
1. Pain less than daily
2. Pain daily

b. INTENSITY of pain
1. Mild pain
2. Moderate pain
3. Times when pain is horrible or excrutiating

J4. ACCIDENTS — (***Check all that apply***)

Fell in **past 30 days** **a.** | Fell in **past 31-180 days** **b.** | Hip fracture in **last 180 days** **c.** | Other fracture in **last 180 days** **d.** | *NONE OF ABOVE* **e.**

J5. STABILITY OF CONDITIONS — Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating) **a.**
Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem **b.**
End-stage disease, 6 or fewer months to live **c.**
NONE OF ABOVE **d.**

K3. WEIGHT CHANGE

a. Weight loss—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
0. No 1. Yes

b. Weight gain—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
0. No 1. Yes

K5. NUTRITIONAL APPROACHES

Feeding tube **b.**
On a planned weight change program **h.**
NONE OF ABOVE **i.**

M1. ULCERS (Due to any cause) — (*Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during* ***last 7 days****. Code 9 = 9 or more.)* ***[Requires full body exam.]***

	Number at Stage
a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	

M2. TYPE OF ULCER — (*For each type of ulcer,* ***code for the highest stage in the last 7 days*** *using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4*)

a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue
b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities

N1. TIME AWAKE — (***Check appropriate time periods over last 7 days***)
Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:
Morning **a.** | Evening **c.**
Afternoon **b.** | *NONE OF ABOVE* **d.**

(If resident is comatose, skip to Section O)

N2. AVERAGE TIME INVOLVED IN ACTIVITIES — (**When awake and not receiving treatments or ADL care**)
0. Most—more than 2/3 of time
1. Some—from 1/3 to 2/3 of time
2. Little—less than 1/3 of time
3. None

O1. NUMBER OF MEDICATIONS — (***Record the number of different*** *medications used in the* ***last 7 days****; enter "0" if none used*)

O4. DAYS RECEIVED THE FOLLOWING MEDICATION — (***Record the number of DAYS*** *during* ***last 7 days****; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)

a. Antipsychotic | **b.** Antianxiety | **c.** Antidepressant | **d.** Hypnotic | **e.** Diuretic

P4. DEVICES AND RESTRAINTS — *Use the following codes for* ***last 7 days***:
0. Not used
1. Used less than daily
2. Used daily

Bed rails
a. — Full bed rails on all open sides of bed
b. — Other types of side rails used (e.g., half rail, one side)
c. Trunk restraint
d. Limb restraint
e. Chair prevents rising

Q2. OVERALL CHANGE IN CARE NEEDS — Resident's overall level of self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support

R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete — Month / Day / Year

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

DISCHARGE TRACKING FORM [*do not use for temporary visits home*]

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ⊛	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	GENDER ⊛	1. Male 2. Female
3.	BIRTHDATE ⊛	Month — Day — Year
4.	RACE/ ETHNICITY ⊛	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY AND MEDICARE NUMBERS ⊛ [C in 1st box if non med. no.]	**a.** Social Security Number — — **b.** Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ⊛	**a.** State No. **b.** Federal No.
7.	MEDICAID NO. [*"+" if pending, "N" if not a Medicaid recipient*] ⊛	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] **a.** Primary reason for assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		

SECTION AB. DEMOGRAPHIC INFORMATION

[*Complete only for stays less than 14 days*] (AA8a=8)

1.	DATE OF ENTRY	*Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date* Month — Day — Year
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

6.	MEDICAL RECORD NO.	

SECTION R. ASSESSMENT/DISCHARGE INFORMATION

3.	DISCHARGE STATUS	**a.** *Code for resident disposition upon discharge* 1. Private home/apartment with no home health services 2. Private home/apartment with home health services 3. Board and care/assisted living 4. Another nursing facility 5. Acute care hospital 6. Psychiatric hopital, MR/DD facility 7. Rehabilitation hospital 8. Deceased 9. Other **b.** *Optional State Code*
4.	DISCHARGE DATE	*Date of death or discharge* Month — Day — Year

⊛ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter **a.** = When letter in box, check if condition applies

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

REENTRY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ⊕	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	GENDER ⊕	1. Male 2. Female
3.	BIRTHDATE ⊕	Month — Day — Year
4.	RACE/ ETHNICITY ⊕	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY ⊕ AND MEDICARE NUMBERS ⊕ [C in 1st box if non med. no.]	**a.** Social Security Number — — **b.** Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ⊕	**a.** State No. **b.** Federal No.
7.	MEDICAID NO. [*"+" if pending, "N" if not a Medicaid recipient*] ⊕	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] **a.** Primary reason for assessment 9. Reentry

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

4a.	DATE OF REENTRY	**Date of reentry** Month — Day — Year
4b.	ADMITTED FROM (AT REENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other
6.	MEDICAL RECORD NO.	

⊕ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter **a.** = When letter in box, check if condition applies

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

Correction Request Form

Use this form (1) to request correction of error(s) in an MDS assessment record or error(s) in an MDS Discharge or Reentry Tracking form record that has been previously accepted into the State MDS database, (2) to identify the inaccurate record, and (3) to attest to the correction request. A correction request can be made to either MODIFY or INACTIVATE a record.

TO MODIFY A RECORD IN THE STATE DATABASE:
1. Complete a new corrected assessment form or tracking form. Include all the items on the form, not just those in need of correction;
2. Complete and attach this Correction Request Form to the corrected assessment or tracking form;
3. Create a new electronic record including the corrected assessment or tracking form AND the Correction Request Form; and
4. Electronically submit the new record (as in #3) to the MDS database at the State.

TO INACTIVATE A RECORD IN THE STATE DATABASE:
1. Complete this correction request form;
2. Create an electronic record of the Correction Request Form; and
3. Electronically submit this Correction Request record to the MDS database at the State.

PRIOR RECORD SECTION.
THIS SECTION IDENTIFIES THE ASSESSMENT OR TRACKING FORM THAT IS IN ERROR. (***In this section, reproduce the information EXACTLY as it appeared in the erroneous record, even if the information is wrong. This information is necessary in order to locate the record in the State database.***)

Prior AA1.	RESIDENT NAME	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
Prior AA2.	GENDER	1. Male 2. Female
Prior AA3.	BIRTHDATE	Month — Day — Year
Prior AA5.	SOCIAL SECURITY	**a.** Social Security Number
Prior AA8.	REASONS FOR ASSESSMENT	**a.** Primary reason for assessment ASSESSMENT (Complete Prior Date item Prior A3a *ONLY*) 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* DISCHARGE TRACKING (Complete Prior Date item Prior R4 *ONLY*) 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. DIscharged prior ro completing initial assessment REENTRY TRACKING (Complete Prior Date item Prior A4a *ONLY*) 9. Rentry **b. *Codes for assessments required for Medicare PPS or the State*** *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*
	PRIOR DATE	(***Complete one only***) Complete Prior A3a if Primary Reason (Prior AA8a) equals 1, 2, 3, 4, 5, 10, or 0. Complete Prior R4 if Primary Reason (Prior AA8a) equals 6, 7, or 8. Complete Prior A4a if Primary Reason (Prior AA8a) equals 9.
Prior A3.	ASSESSMENT REFERENCE DATE	**a.** *Last day of MDS observation period* Month — Day — Year
Prior R4.	DISCHARGE DATE	*Date of discharge* Month — Day — Year
Prior A4a.	DATE OF REENTRY	*Date of reentry* Month — Day — Year

CORRECTION ATTESTATION SECTION.
COMPLETE THIS SECTION TO EXPLAIN AND ATTEST TO THE CORRECT REQUEST

AT1.	ATTESTATION SEQUENCE NUMBER	(*Enter total number of attestations for this record, including the present one*)
AT2.	ACTION REQUESTED	1. MODIFY record in error (*Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY.* ***Proceed to item AT3 below.***) 2. INACTIVE record in error. (*Do NOT submit an assessment or tracking form. Submit the correction request only.* ***Skip to item AT4.***)

AT3.	REASONS FOR MODIFICATION	(***If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5***) a. Transcription error b. Data entry error c. Software product error d. Item coding error e. Other error *If "Other" checked, please specify:* _____
AT4.	REASONS FOR INACTIVATION	(***If AT2=2, check at least one of the following reasons; check all that apply.***) a. Test record submitted as production record b. Event did not occur c. Inadvertent submission of inappropriate record d. Other reason requiring inactivation *If "Other" checked, please specify:* _____

RN COORDINATOR ATTESTATION OF COMPLETION

AT5.	ATTESTING INDIVIDUAL NAME	**a.** (First) **b.** (Last) **c.** (Title)
	SIGNATURE	
AT6.	ATTESTATION DATE	Month — Day — Year

AT7. ATTESTATION OF ACCURACY AND SIGNATURES OF PERSONS WHO CORRECT A PORTION OF ASSESSMENT OR TRACKING INFORMATION

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Attestation Date
a.	
b.	
c.	
d.	
e.	
f.	

B. Preadmission Screening and Annual Resident Review (PASARR)

Preadmission screening and annual resident review (PASARR) are required to determine whether persons with a diagnosis or other indications of mental illness, mental retardation, or related conditions:

- Have needs which are primarily for nursing and medical care, or
- Require specialized services for their mental disability.

Do not admit a new resident with mental illness or mental retardation unless the Division of Mental Health and Developmental Disabilities has approved the admission, based on an independent physical and mental health evaluation.

For the screening process, "mental illness" is defined as a current primary or secondary diagnosis of a major mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, most current edition). It is limited to schizophrenic, paranoid, major affective, and schizoaffective disorders and atypical psychosis. It does not include a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

For the screening process, "mental retardation" is defined as a level of retardation (mild, moderate, severe and profound), as described in the American Association on Mental Deficiency's Manual on Classification in Mental Retardation (1983). Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

For the screening process, a "related condition" means a severe, chronic disability that meets all the following conditions:

- It is attributable to cerebral palsy, epilepsy, or any condition (other than mental illness) which is found to be closely related to mental retardation because this condition:
  - Results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and
  - Requires treatment or services similar to those required for these persons. This includes autism.
- It is manifested before the person reaches age 22.
- It is likely to continue indefinitely.
- It results in substantial functional limitations in three or more of the following areas of major life activity:
  - Self-care
  - Understanding and use of language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living

The PASARR process includes two screening levels. Level I is performed by the Iowa Foundation for Medical Care (IFMC). Facilities are responsible for the completion of Level II screens. The following sections explain the requirements for:

- Identification of mental retardation or mental illness (Level I screening).
- Evaluation of services needed (Level II screening).
- Evaluation of persons with mental illness.
- Evaluation of persons with mental retardation.
- Active treatment for persons with mental illness or mental retardation.
- Annual review of resident needs.

1. Identification of Mental Retardation or Mental Illness (Level I)

The IFMC must screen all persons presenting for admission to a nursing facility before admission to determine whether they have or are suspected of having mental illness, mental retardation, or a related condition.

IFMC conducts this review for Medicaid recipients in conjunction with the level of care review. IFMC completes the Level I for private pay residents through the MDS data submitted to the state repository.

IFMC mails validation sheets to facilities each month for the previous month's Level I screenings. The sheets identify the results of the Level I screens and indicate whether Level II evaluations were required. Place these in the resident's record and keep them as a permanent part of the chart.

Exceptions to the Level I screening are permitted in the following circumstances:

- Persons previously approved for nursing facility placement who are being readmitted from a non-medical setting within one year of their last PASARR screen and are not a danger to themselves or others are exempt from preadmission screening.
- Persons who are being readmitted to a nursing facility after a hospital stay do not require screening.
- Persons who have been screened within the past 12 months may transfer to another facility at the same level of care without being screened again if their condition has not changed significantly.
- Persons admitted for respite care for less than 30 days do not require the preadmission screening. Screening is required if it is determined that the resident will not be discharged within the 30 days.
- Persons admitted to a nursing facility directly from the hospital who require nursing services for the same condition that caused the hospitalization do not require screening when the attending physician certifies in writing that the person's expected length of stay is 30 days or less.

- If a resident of a continuing care retirement community requires infirmary care at nursing facility level within the complex, a preadmission screening is not necessary if certain conditions are met. The expected length of stay must be no longer than 30 days, and the physician's order must designate the length of stay.

2. Evaluation of Services Needed (Level II)

Residents identified through the Level I preadmission screening process as having or suspected of having mental illness, mental retardation, or related conditions must have further evaluation before admission to a nursing facility.

The purpose of this extended evaluation is to determine whether the person requires the level of services provided by a nursing facility and whether the person's service needs can be met in the nursing facility.

If IFMC reviewers identify that a Level II evaluation is required following Level I screening, the Level II evaluation must be completed before IFMC will conduct the remainder of the admission review. Approval for level of care cannot be given until all required information is available.

This means that if the person refuses, or the physician or facility refuses to perform Level II evaluations, medical eligibility will not be assigned. The facility will not receive Medicaid reimbursement for the care of that resident.

There is no age limit when considering the necessity for Level II evaluations. Persons must be evaluated regardless of age if the Level I review indicates the evaluation is needed.

The following sections explain:

- Exceptions to the requirement for a Level II evaluation.
- The process for Level II evaluations.

a. Exceptions to Evaluation Requirement

Exceptions to the Level II evaluation are as follows:

- Convalescent Care: Nursing facilities may admit residents for medically necessary recovery following acute hospitalization for a period of up to 120 days without a Level II evaluation if they are not a danger to themselves or others.

  IFMC will monitor these residents. At the end of 120 days, IFMC will verify with facilities that a Level II evaluation has been performed and will review the results of those evaluations.

  This exemption may apply when a patient was discharged for a trial period to home or another setting following hospitalization but is later admitted to the nursing facility for convalescent care. The exemption applies if the patient is admitted to the nursing facility for convalescent care within 30 days of discharge from the hospital.

- Terminal Illness: Facilities may admit residents with mental illness or mental retardation without a Level II evaluation if their attending physician certifies that they are terminally ill (meaning death is expected within six months), they require nursing care or supervision due to their physical condition, and they are not a danger to themselves or others.

- Severity of Illness: Residents whose severity of illness prevents participation in active treatment are exempt from Level II evaluation if they are not a danger to themselves or others. Persons exempt under this category include those who:

  - Are comatose.
  - Function at brain-stem level.
  - Are ventilator-dependent.
  - Have severe medical disabilities related to diagnosis of Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis, COPD, CHF, and others as determined through the review process.

- Temporary Condition: Confusion related to organic causes or to a medical condition (e.g., diabetes out of control or recent CVA) is an acceptable reason for exemption from Level II evaluations. This exemption applies only if the person being reviewed has no other diagnosis or symptoms of mental illness or mental retardation.

  The IFMC reviewer will complete Level I screening and go on to complete the rest of the review. If the person meets the level of care, medical approval will be given for 90 days.

  At the end of 90 days, the IFMC reviewer will assess the resident again. If the confusion has not cleared, and there is no corresponding documentation by the physician regarding the cause of the confusion, the resident must have a Level II evaluation performed.

- Previous Evaluation: Residents with approved specialized services and therapies needs who transfer to another facility do not have to repeat the evaluation and review process if:

  - These specialized services and therapies still meet the service needs of the resident, and
  - The receiving facility agrees to provide these specialized services and therapies.

b. Evaluation Process

The Health Care Financing Administration has specified the types of information that must be included in the Level II screening process. It is the responsibility of the facility to ensure these elements are addressed in the evaluation.

The evaluation may be done by staff of a referring agency, by outside agency staff, or by facility staff when outside professionals are not available. The Department reserves the right to review qualifications of staff or consultants performing these evaluations.

There is no standard format for the PASARR evaluations. However, the federal criteria described below must be included as a minimum. For persons who have both mental illness and mental retardation, both sets of criteria must be addressed.

The evaluation must be accurate and correspond to the person's current functional level. It must be descriptive. Reports of diagnosis, numerical test scores, quotients, developmental levels, etc., are not acceptable in the absence of a specific description identifying what they mean in terms of the person's functional status.

Information up to 12 months old may be used if it reflects the current status of the resident. There must be a signed and dated statement to that effect by the persons authorized to complete the evaluation.

The evaluation must be presented in a report that includes:

- Identification of the name, title, and date on which each portion of the assessments was administered;
- A summary of the person's positive traits or developmental strengths and weaknesses or developmental needs; and
- Identification of the mental retardation services required to meet the person's identified needs, regardless of the availability of those services to be provided directly by a nursing facility.

The evaluation must be interpreted to the person, and the parent of a minor person or the legal guardian if available. Copies of all reports written as part of the Level II evaluations must belong to the client and be retained for use by the facility serving the client.

3. Evaluation of Persons With Mental Illness

A physician (including board-certified or board-eligible psychiatrist) or a certified health services provider in psychology must conduct the psychiatric portion of the evaluation. A board-certified or board-eligible psychiatrist must countersign the evaluation if it is not completed by a physician or certified psychologist.

The purpose of the evaluation should be to determine, as a result of the data obtained, whether or not the person with mental illness needs the implementation of an active treatment program for mental illness.

The evaluation process should ensure that, based on the data compiled, a board-certified psychiatrist validates the diagnosis of mental illness and determines whether a program of psychiatric active treatment is needed.

The following sections explain the requirements for:

- A physical examination.
- Evaluation of drug use.
- A psychosocial evaluation.
- A psychiatric evaluation.
- A functional assessment.

a. Physical Examination

The PASARR/MI process should include a comprehensive history and physical examination of the person. At a minimum, the examination must address the following areas (if not previously addressed):

- Complete medical history.
- Review of all body systems.
- Specific evaluation of the person's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes.

If abnormal findings are the basis for a nursing facility placement, appropriate specialists should conduct additional evaluations. If a physician does not performed the history and physical examination, then a physician's review and concurrence with the conclusions is required.

b. Drug Use

The evaluation should provide a comprehensive drug history of all current or immediate past use of medications that could mask symptoms or mimic mental illness.

c. Psychosocial Evaluation

The psychosocial evaluation of the person should include an evaluation of at a minimum, current living arrangements and medical and support systems. If a social worker does not conducted the psychosocial evaluation, then a social worker's review and concurrence with the conclusions is required.

d. Psychiatric Evaluation

The evaluation should include a comprehensive psychiatric evaluation. At a minimum, this evaluation should address the following areas:

- Complete psychiatric history.
- Evaluation of intellectual functioning, memory functioning, and orientation.
- Description of current attitudes and overt behaviors.
- Affect.
- Suicidal or homicidal ideation.
- Degree of reality testing (presence and content of delusions) and hallucinations.

If the psychiatric evaluation is performed by staff of an accredited community mental health center, a mental health professional must perform the evaluation.

If the psychiatric evaluation is not performed by staff of an accredited community mental health center, a board-certified or board-eligible psychiatrist or a certified health services provider in psychology must perform the evaluation.

e. Functional Assessment

The evaluation should include a functional assessment of:

- The person's ability to engage in activities of daily living.
- The level of support that would be needed to assist the person to perform these activities while living in the community.

The assessment should determine whether this level of support:

- Can be provided in an alternative community setting, or
- Is such that nursing facility placement is required.

At a minimum, this evaluation should address:

- Self-monitoring of health status.
- Self-administering and scheduling of medical treatments.
- Medication compliance.
- Self-monitoring of nutritional status.
- Handling money.
- Dressing appropriately.
- Grooming.

4. Evaluation of Persons With Mental Retardation or Related Conditions

For a person with mental retardation or related condition, it is recommended that a qualified mental retardation professional complete the evaluation. At a minimum, the professional completing the assessment should have a basic understanding of mental retardation or related conditions and the specialized services to meet the client's needs.

Federal regulations define a qualified mental retardation professional as a person who has at least one year of experience working directly with persons with mental retardation or other developmental disabilities, and is either:

- A doctor of medicine or osteopathy,
- A registered nurse, or
- A person who is eligible for certification as a physical or occupational therapist or who holds at least a bachelor's degree in psychology, social services, speech-language pathology, recreation therapy, dietetics, or any human services field.

The evaluation should ensure that a psychologist who meets the qualifications of a qualified mental retardation professional:

- Identifies the person's intellectual functioning measurement.
- Validates that the person has mental retardation or is a person with a related condition.

The purpose of the evaluation should be to determine whether the person needs the implementation of a continuous active treatment program, as defined.

The following sections explain the requirements for:

- A history and physical examination.
- A functional assessment.
- Indicators of a need for active treatment.

a. History and Physical Examination

The evaluation should review the person's comprehensive history and physical examination results and identify at least:

- A list of the person's medical problems.
- The impact these problems have on the person's independent functioning.
- A list of all current medications the person uses.

- The person's current response to any prescribed medications in the following drug groups:
  - Hypnotics.
  - Antipsychotics (neuroleptics).
  - Mood stabilizers and antidepressants.
  - Antianxiety-sedative agents.
  - Anti-Parkinsonian agents.

The evaluation should assess the person's self-monitoring of health status, self-administering and scheduling of medical treatments, and self-monitoring or nutritional status.

b. Functional Assessment

The evaluation should also assess:

- Self-help development (such as toileting, dressing, grooming, and eating).
- Sensorimotor development, such as ambulation, positioning, transfer skills, gross motor dexterity, visual motor perception, fine motor dexterity, eye-hand coordination, and extent to which prosthetic, orthotic, corrective or mechanical supportive devices can improve the individual's functional capacity.
- Speech and language (communication) development, such as expressive verbal and nonverbal language, receptive verbal and nonverbal language, extent to which nonoral communication systems can improve the person's function capacity, auditory functioning, and extent to which amplification devices (e.g., hearing aid) or a program of amplification can improve the person's functional capacity.
- Social development, such as interpersonal skills, recreation and leisure skills, and relationships with others.
- Academic educational development, including functional learning skills.

- Independent living development, such as meal preparation, budgeting and personal finances, survival skills, mobility skills (orientation to the neighborhood, town, city), laundry, housekeeping, shopping, bed making, care of clothing, and orientation skills (for persons with visual impairments).
- Vocational development, including present vocational skills.
- Affective development, such as interests, and skills involved with expressing emotions, making judgments, and making independent decisions.
- Presence of identifiable maladaptive or inappropriate behaviors based on systematic observation (including, but not limited to, the frequency and intensity of identified maladaptive or inappropriate behaviors).

c. Indicators of Need for Active Treatment

The evaluation should review the data collected and identify to what extent the person's status compares with each of the following characteristics commonly associated with a need for active treatment:

- Inability to take care of most personal care needs;
- Inability to understand simple commands;
- Inability to communicate basic needs and wants;
- Inability to be employed at a productive wage level without systematic long-term supervision or support;
- Inability to learn new skills without aggressive and consistent training;
- Inability to apply skills learned in a training situation to other environments or settings without aggressive and consistent training;
- Inability to demonstrate behavior appropriate to the time, situation or place without direct supervision;
- Demonstration of severe maladaptive behavior which places the person or others in jeopardy to health and safety;

- Inability or extreme difficulty in making decisions requiring informed consent; and
- Presence of other skill deficits or specialized training needs which necessitates the availability of trained mental retardation personnel 24 hours per day to teach the person functional skills.

5. Active Treatment

A person who has mental retardation, a related condition, or mental illness can live in a nursing facility if:

- The person requires that level of nursing care, and
- The facility will be able to meet or arrange for the active treatment needs of that person.

The federal Health Care Financing Administration has defined "active treatment" as follows:

- For persons with mental retardation or a related condition, active treatment means a continuous program for each person that includes aggressive, consistent implementation of specialized and generic training, treatment, health services, and related services that are directed towards:
  - The acquisition of the behaviors necessary for the person to function with as much self-determination and independence as possible, and
  - The prevention or deceleration of regression or loss of current optimal functional status.

  Active treatment does not include services to maintain generally independent persons who are able to function with little supervision or in the absence of a continuous active treatment program.

- For persons with mental illness, active treatment is defined as the implementation of an individualized plan of care:
  - Developed under and supervised by a physician.
  - Provided by a physician and other qualified mental health professionals.
  - That prescribes specific therapies and activities for the treatment of an acute episode of severe mental illness or long-term, chronic mental illness that necessitates supervision by trained mental health personnel.

The premise behind active treatment is simply that all people should have the chance for growth and all daily activities should provide an opportunity for learning.

An active treatment program is a goal-oriented program that is determined by the person's weakness or needs and built on the person's strengths. These strengths and needs are identified through the assessment process.

For example, if the assessment indicates that a person is not able to feed herself, the facility should initiate a program for learning this skill at the learning opportunity provided at mealtimes.

The nursing facility may or may not provide the needed service, depending on the needs identified. However, if the facility does not provide the service, it must ensure that it is provided elsewhere.

If a resident is in need of individual counseling, the nursing facility may use a community mental health center. If a resident is in need of social training, the facility may use a local day program or activity center.

In summary, active treatment means that training is provided to allow each person to be as independent as possible, and that services are provided based on individual needs.

The facility in conjunction with the county Department office must arrange for or provide appropriate services to meet the individual needs of the resident. If the person's needs are so extensive that they require continuous programming, then placement in an intermediate care facility for the mentally retarded or a mental health institute must be considered.

C. Comprehensive Care Plans

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and psychosocial needs identified in the comprehensive assessment.

The plan of care must deal with the relationship of items or services ordered to be provided (or withheld) to the facility's responsibility for fulfilling other requirements in these rules.

The plan must be developed:

- Within seven days after an interdisciplinary team completes the comprehensive assessment.
- With the participation of the resident and the resident's family or legal representative, to the extent practicable.

The interdisciplinary team must include the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.

The services provided or arranged by the facility must meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care. The plan must be reviewed periodically and must be revised by a team of qualified persons after each assessment.

D. Physician Services

A physician must personally approve in writing a recommendation that a person be admitted to a facility. Each resident must remain under the care of a physician.

The facility must:

- Ensure that the medical care of each resident is supervised by a physician.
- Ensure that another physician supervises the medical care of residents when their attending physician is unavailable.
- Provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

A physician must see all nursing facility residents at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than ten days after the date the visit was required. All required physician visits must be made by the physician personally.

The physician must:

- Review the resident's total program of care, including medications and treatments, at each visit.
- Write, sign and date progress notes at each visit.
- Sign and date all orders.

Note: Any required physician task in a nursing facility may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility, but who is working in collaboration with a physician, except where prohibited by state law. This includes tasks which the rules specify must be performed personally by the physician.

E. Nursing Services

Based on the comprehensive assessment of a resident, the facility must ensure that:

- A resident's abilities in activities of daily living do not diminish unless circumstances of the resident's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress and groom, transfer and ambulate, toilet, eat, and use speech, language or other functional communication systems.
- A resident is given the appropriate treatment and services to maintain or improve the resident's abilities to perform activities of daily living.
- A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.
- Each resident receives adequate supervision and assistive devices to prevent accidents.
- A resident who enters the facility without a limited range of motion does not experience reduction in range of motion, unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.
- A resident with a limited range of motion receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion.
- A resident who is incontinent of bladder receives the appropriate treatment and services to:
  - Restore as much normal bladder functioning as possible.
  - Prevent urinary tract infections and to restore as much normal bladder function as possible.

- A resident who enters the facility without an indwelling catheter is not catheterized, unless the resident's clinical condition demonstrates that catheterization was necessary.
- A resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the resident's clinical condition demonstrates that they were unavoidable.
- A resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.
- A resident who has been able to eat enough alone or with assistance is not fed by nasogastric tube, unless the resident's clinical condition demonstrates that use of a nasogastric tube was unavoidable.
- A resident who is fed by a nasogastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore normal feeding functions if possible.

The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

The facility must ensure that residents receive proper treatment and care for the following services:

- Injections
- Parenteral and enteral fluids
- Colostomy, ureterostomy or ileostomy care
- Tracheostomy care
- Tracheal suctioning
- Respiratory care
- Foot care
- Prostheses

F. Dietary Services

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

The facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem. Therapeutic diets must be prescribed by the attending physician. The facility must provide special eating equipment and utensils for residents who need them.

Menus must be prepared in advance and be followed. The menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day.

The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

The facility must procure food from sources approved or considered satisfactory by federal, state or local authorities. The facility must store, prepare, distribute and serve food under sanitary conditions and must dispose of garbage and refuse properly.

Each resident must receive and the facility must provide food prepared by methods that conserve nutritive value, flavor and appearances. The food must be palatable, attractive and at the proper temperature. Food must be prepared in a form designed to meet individual needs. Substitutes of similar nutritive value must be offered to residents who refuse food served.

G. Pharmacy Services

A facility must provide pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement. The facility may permit a certified medication aide to administer drugs, but only under the general supervision of a licensed nurse.

The facility must label drugs and biologicals in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date, when applicable.

In accordance with state and federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of l976 and other drugs subject to abuse. (This is not required when the facility uses single-unit-package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.)

A licensed pharmacist must review the drug regimen of each resident at least once a month. The pharmacist must report any irregularities to the attending physician and the director of nursing, and these reports must be acted upon.

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

- In excessive dose, including duplicate drug therapy, or
- For excessive duration, or
- Without adequate monitoring, or
- Without adequate indications for its use, or
- In the presence of adverse consequences which indicate the dose should be reduced or discontinued, or
- Any combinations of the reasons above.

The facility must ensure that residents who have not used antipsychotic drugs are not given these drugs, unless antipsychotic drug therapy is necessary to treat a specific condition, as diagnosed and documented in the clinical record.

Residents who use antipsychotic drugs must receive gradual dose reductions and behavioral programming, unless clinically contraindicated in an effort to discontinue these drugs.

The facility must ensure that it is free of significant medication error rates and that residents are free of any significant medication error rates of 5 percent or greater.

H. Social Services and Activities

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

The facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

The facility must ensure that a resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction or increased withdrawn, angry or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident.

I. Specialized Rehabilitative Services

If specialized rehabilitative services are required in the resident's comprehensive plan of care, the facility must provide these services or obtain them from an outside provider of specialized rehabilitative services. This includes services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and health rehabilitative services for mental illness and mental retardation.

J. Laboratory Services

The facility must provide or obtain clinical laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

If the facility does not provide laboratory services on site, it must have an agreement to obtain these services only from a laboratory that meets federal requirements or from a physician's office.

If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be approved or licensed to test specimens in the appropriate specialties or subspecialties of service.

If the facility provides its own laboratory services, the services must meet the conditions for coverage of the services furnished by laboratories. If the facility provides blood bank and transfusion services, it must meet the requirements for laboratories.

The facility must provide or obtain laboratory services only when ordered by the attending physician. The facility must assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance. The facility must promptly notify the attending physician of the findings and must file signed and dated reports of clinical laboratory services in the resident's clinical record.

K. Radiology and Other Diagnostic Services

The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals. If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier approved to provide these services under Medicare.

The facility must provide or obtain radiology and other diagnostic services only when ordered by the attending physician. The facility must assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.

The facility must promptly notify the attending physician of the findings and file signed and dated reports of X-ray and other diagnostic services in the resident's clinical record.

L. Dental, Vision, and Hearing Services

The facility must provide or obtain from an outside resource routine dental services (to the extent covered under Medicaid) and emergency dental services to meet the needs of each resident.

The facility must assist residents in obtaining routine and 24-hour emergency dental care. The facility must promptly refer residents with lost or damaged dentures to a dentist. If necessary, the facility must assist the resident in making appointments and arranging for transportation to and from the dentist's office.

To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must assist a resident in making appointments with:

- A medical practitioner specializing in the treatment of vision or hearing impairment.
- A professional specializing in the provision of vision or hearing assistive devices.

The facility must also assist residents in arranging for transportation to and from the office of these providers, if necessary.

M. Quality Assessment and Assurance

A facility must maintain a quality assessment and assurance committee consisting of:

- The director of nursing services,
- A physician designated by the facility, and
- At least three other members of the facility's staff.

The quality assessment and assurance committee must:

- Meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary.
- Develop and implement appropriate plans of action to correct identified quality deficiencies.

The state or the Department of Health and Human Services may not require disclosure of the records of the committee, except as the disclosure relates to the compliance of the committee with these requirements.

VI. RESIDENT RIGHTS

A facility must protect and promote the rights of each resident. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The resident has the right to:

- Be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.
- Exercise rights as a resident of the facility and as a citizen of the United States.
- Be free of interference, coercion, discrimination, or reprisal from the facility in exercising those rights.

When the resident is adjudged incompetent under state law, the resident's rights are exercised by the person appointed under state law to act on the resident's behalf.

When a resident has not been adjudged incompetent by the state court, any legal-surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

The facility must post the names, addresses, and telephone number of all pertinent state client advocacy groups. This includes the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit, as follows:

Health Facilities Division
Dept. of Inspections and Appeals
Lucas Building
Des Moines, IA 50319-0075
(515) 281-4115

Ombudsman
Dept. of Elder Affairs
200 10th Street
Des Moines, IA 50309
(515) 281-5187

Iowa Protection & Advocacy Services
3015 Merle Hay Road
Des Moines, IA 50310
(515) 278-2502

Fraud Control Bureau
Dept. of Inspections and Appeals
Lucas Building
Des Moines, IA 50319-0075
(515) 281-7107

The following sections cover policies on:

- Nondiscrimination
- Free choice of treatment
- Freedom of association
- Privacy and confidentiality
- Personal property and funds
- Grievances

A. Nondiscrimination

Compliance with Title VI of the Civil Rights Act of 1964 is a condition of participation for the Medicaid program. Facilities must not discriminate on the basis of race, color, or national origin.

All referrals under Medicaid must be made on a nondiscriminatory basis. The facility must effectively convey to the community, to hospitals, and other referral sources, its nondiscriminatory policy and the nature and extent of services available.

Compliance with Title VI requires adherence to the policies and practices outlined under Item III.B.2, **Admissions Policy**. Where there is a significant variation between the racial or ethnic composition of the resident census and available population census data for the potential service area, the facility has a responsibility to determine the reason for the variation and take whatever action may be necessary to correct any discrimination.

Residents' privileges and care services, such as medical and dental care, nursing, laboratory services, pharmacy, physical, occupational and recreational therapies, social services, volunteer services, dietary service, and housekeeping services must be provided on a nondiscriminatory basis. Physical facilities, including lounges, dining facilities, lavatories and beauty and barber shops, must be provided and used without discrimination.

Rules of courtesy must be uniformly applied without regard to race, color, or national origin in all situations, including face-to-face contact and written records and communications. Assignment of staff to residents must not be governed by the race, color, or national origin of either resident or staff.

Residents must be assigned to rooms, wards, floors, sections, buildings and other areas without regard to race, color, or national origin. Room assignments must result in a degree of multiracial occupancy of multibed accommodations which reflects the proportion of minority use of the facility.

Residents must not be asked whether they are willing to share accommodations with persons of a different race, color, or national origin. Requests from residents for transfer to other rooms in the same class of accommodations must not be honored if based on racial or ethnic considerations.

Exceptions may be made only if the attending physician or facility administrator certifies in writing that there are valid medical reasons or special compelling circumstances in the individual case. However, such certifications may not be used to permit segregation as a routine practice in the facility.

Privileges of attending residents in the nursing facility must be granted to physicians and other health professionals without discrimination. Nursing facility referrals, including but not limited to referrals to other facilities and care programs, must be made in a manner which does not result in discrimination.

B. Free Choice of Treatment

Residents have the right to choose a personal attending physician. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for the resident's care.

Unless adjudged incompetent or otherwise found to be incapacitated under the state law, the resident has the right to participate in planning care and treatment or changes in care and treatment.

The resident has the right to be fully informed in language that the resident can understand of the resident's total health status, including, but not limited to, medical condition. Residents have the right to refuse treatment and to refuse to participate in experimental research.

Residents have the right to examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The results must be in a place readily accessible to residents.

Residents have the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. A facility must immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is:

- An accident involving the resident which results in injury and has the potential for requiring physician intervention,
- A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications),
- A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment), or
- A decision to transfer or discharge the resident from the facility.

Except in a medical emergency, the facility must also notify the resident's physician and the resident's legal representative or interested family member within 24 hours of one of these events. In an emergency, notification must be made immediately.

A resident has the right to self-administer drugs if the interdisciplinary team has determined that this practice is safe. Residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

Residents have the right to choose activities, schedules, and health care consistent with the resident's interests, assessments and plans of care. The resident may make choices about aspects of life in the facility that are significant to the resident.

Residents have the right to refuse to perform services for the facility or to perform services for the facility if the resident chooses. The facility must document the resident's need or desire for work in the plan of care and specify in the plan the nature of the services performed and whether the services are voluntary.

Compensation for paid services must be at or above prevailing rates, and the resident must agree to the work arrangement described in the plan of care.

C. Freedom of Association

A married couple has the right to share a room when both spouses live in the same facility and both consent to the arrangement. The facility must promptly notify the resident and the resident's legal representative or interested family member, if known, when there is a change in room or roommate assignment.

A person has the right to refuse a transfer to another room within the facility, if the purpose of the transfer is to relocate a resident from the distinct part of the facility that is a skilled nursing facility to a part of the facility that is not a skilled nursing facility or vice versa. A resident's exercise of this right does not affect the resident's eligibility or entitlement to Medicaid benefits.

Residents have the right to have reasonable access to the use of a telephone where calls can be made without being overheard. Residents have the right to privacy in written communications, including the right to send and receive mail promptly that is unopened and to have access to stationery, postage, and writing implements at the resident's own expense.

Residents have the right to receive visitors. The facility must allow access to the resident for the visitors at any reasonable hour. The facility must provide immediate access to any resident by immediate family, relatives, or others who are visiting with the consent of the resident. Access must be subject to the resident's right to deny or withdraw consent at any time.

The resident also has the right to immediate access to:

- The resident's individual physician.
- Any representative of the state or the U. S. Department of Health and Human Services.
- The state long-term care ombudsman and the agency responsible for the protection and advocacy system for persons with developmental disabilities.

The facility must provide reasonable access to the resident for any entity or person that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

D. Privacy and Confidentiality

Residents have the right to personal privacy and confidentiality of personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility to provide a private room.

The resident may approve or refuse the release of personal and clinical records to any person outside the facility, except when the resident is transferred to another health care institution or record release is required by law. Residents have the right to inspect and purchase photocopies of all records pertaining to the resident upon written request and 24 hours' notice to the facility.

E. Personal Property and Funds

Residents have the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

Residents have the right to manage their own financial affairs. The facility may not require residents to deposit their personal funds with the facility. Upon written authorization of a resident, the facility must hold, safeguard, manage and account for the personal funds of the resident deposited with the facility.

F. Grievances

Residents have the right to voice grievances without discrimination or reprisal for voicing the grievances. The grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.

Residents may participate in resident and family groups. When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

VII. MEDICAID ELIGIBILITY

As noted under Item III.B.3, **Notice of Rights and Services**, facilities are required to make information about Medicare and Medicaid benefits available to residents. Department publications about Medicaid which can be used for this purpose include:

- Comm. 20, *Your Guide to Medicaid*
- Comm. 28, *Medicaid for SSI-Related Persons*
- Comm. 30, *Medicaid for the Medically Needy*
- Comm. 52, *Medicaid Information for People in Nursing Homes and Other Facilities*
- Comm. 72, *Protection of Your Resources and Income*

These publications are available from Iowa State Industries at Anamosa. See Section I for information on placing orders.

Financial eligibility for Medicaid is determined by the county Department of Human Services offices under rules established by the Department. (See Chapter C for more information.) No payments will be made for nursing facility care of persons found to be financially ineligible for Medicaid.

Decisions on approval of the level of care are made for the Department by the Iowa Foundation for Medical Care (IFMC). When placement has final medical and financial approval of the Department, payment will be authorized retroactive to the date of the resident's admission to the nursing facility, if appropriate.

The beginning date of eligibility will be no more than 90 days before the first day of the month in which application was filed with the county office of the Department. Eligibility can be granted retroactively for the three months prior to application, provided that eligibility existed at that time.

The following sections cover:

- Procedures for attributing availability of resources between married couples.
- Medicaid application procedures.
- Procedures for obtaining approval of nursing level of care.
- Requirements for submitting a *Case Activity Report*.
- Personal needs allowances for Medicaid recipients.
- Continued stay reviews.

A. Attribution of Resources

The Medicare Catastrophic Coverage Act of 1988 contains "spousal impoverishment" provisions. They require the Department determine the attribution of a married couple's resources to the institutionalized spouse and to the community spouse at the beginning of the continuous period of institutionalization.

The attribution is intended to protect an amount of resources for the community spouse, so that the community spouse will not become impoverished through spending all of the couple's resources for care of the institutionalized spouse.

When one spouse enters a medical institution expecting to stay at least 30 days, the Department will "attribute" their resources to each spouse. Only the resources attributed to the institutionalized spouse are considered in determining initial eligibility.

An attribution of resources is always completed for the month that one spouse enters a medical institution (on or after September 30, 1989) expecting to stay 30 consecutive days when there is a community spouse. Attribution of resources will also be completed for estranged couples.

The Department initiates the attribution of resources when:

- Either spouse requests that the Department determine the attribution of resources at the beginning of the person's continuous stay in a medical institution. This request must be accompanied by form 470-2577, *Resources Upon Entry to Medical Facility*, and necessary documentation.
- The institutionalized spouse or someone acting on that person's behalf applies for Medicaid benefits. If the application is not made in the month of entry, the applicant must also complete form 470-2577 and provide necessary documentation.

The attribution of resources must be completed at the time of original entry of the spouse. Attribution at the time of entry is easier for both the couple and the agency, as verification of resources is more accessible. The resources must be evaluated as of the first moment of the first day of the month to determine their countability or exclusion.

All resources owned by either spouse must be considered in the attribution, except for some resources, such as the home. The amount to attribute does not depend on which spouse owns the resource.

One-half of the documented resources of both the institutionalized and community spouses at the time of the spouse's entry to a medical institution is attributed to each spouse. However, the Department sets a minimum and maximum community spouse resource allowance.

The maximum limit is indexed annually with the Consumer Price Index. When the limit increases, the resources are assessed to determine if the revised maximum will be attributed the community spouse (unless the institutionalized spouse is already eligible).

B. Application Procedures

Facilities should advise persons needing help with the costs of medical care to contact the Department office in the county where they live (or where they will live when they enter the nursing facility).

Persons whose monthly income indicates they would be eligible for SSI must apply for the SSI program at the district office of the Social Security Administration serving the area in which the facility is located. (After the month of entry to the facility, only persons with a monthly income less than $50 need to apply for SSI.)

Persons whose income is over SSI standards must apply to the Department. Such people, commonly referred to as persons in the "300% group," are financially eligible for Medicaid in a nursing facility providing monthly income is not in excess of 300% of SSI income limits and resources are within SSI limits.

Eligibility for these people requires a 30-consecutive-day period of residence in a medical institution, such as a hospital or nursing facility. A resident may have been in more than one facility or needed more than one level of care, but must have been in a medical institution for the 30-day period. Residents whose death occurs during the 30-day period meet this requirement if there was continuous residency.

The Department redetermines ongoing eligibility for Medicaid for persons having monthly income of $50 or more. For persons with monthly income of less than $50, redeterminations of eligibility is done by the Social Security Administration.

All information regarding the case should be sent to the Iowa Foundation for Medical Care and the Department of Human Services' county office (as appropriate) as soon as possible in order to effect prompt approval of the application.

C. Medical Approval

IFMC makes the decision as to medical necessity for nursing care and sends the validation information to the Medicaid fiscal agent. The fiscal agent matches it with financial eligibility data received from the Department.

Facilities must contact the IFMC on, or preferably before, admission of a resident who is expected to be financially eligible for Medicaid. Facilities also must contact IFMC when a resident who has been admitted on private pay decides to apply for Medicaid.

An informational copy of the printout is furnished to the facility. Facility staff should check the printout for accuracy. Any errors noted, such as a misspelling of the resident's name or the date of medical approval, should be reported to the IFMC.

No Medicaid payments can be made until the IFMC has the recipient's Medicaid identification number. Facilities can expedite prompt payment by notifying IFMC of the identification number as soon as it becomes available.

When placement of a nursing facility resident is not approved for medical reasons, the Iowa Foundation for Medical Care notifies the facility of the nonapproval decision by telephone on the day that the decision is made. The facility is responsible for notifying the resident of this decision.

Written confirmation from the IFMC will follow the telephone notification of disapproval. Copies of this written notice are provided to the facility, the resident, the attending physician, and the Department of Human Services.

Upon notice of disapproval, the facility should put the resident's discharge plan into effect, in cooperation with the resident and the resident's family. A Department worker will contact the facility to monitor the progress made in effecting the discharge plan.

D. *Case Activity Report,* Form 470-0042

Form 470-0042, *Case Activity Report,* is used to ensure prompt and accurate reporting on activities of individual Medicaid recipients that occur at the nursing facility. When a resident is enrolled under hospice, the facility is responsible for sending the *Case Activity Report* to the Department.

1. Facsimile of Form

The following pages contain a sample of the *Case Activity Report*.

Iowa Department of Human Services

CASE ACTIVITY REPORT

Complete this form when a Medicaid applicant or recipient enters or leaves your facility, and when a resident of your facility applies for Medicaid. See the back of this form for instructions.

Fold line

Fold line

1. Recipient Data

Name	Social Security Number	State ID	Date Entered Facility

2. Facility Data

Name		Provider Number	DHS Per Diem
City	Signature of Person Completing Form		Date Completed

3. Level of Care

This information is determined by (IFMC, Medicare or by managed care contractor). Provider number in Item 2 must match the new level of care.

Level of Care	Effective Date

4. Medicare Information for Skilled Patients in Skilled Facilities

Do you expect this stay to be covered by Medicare?	Expected dates of full Medicare coverage	Expected dates of partial Medicare coverage
❑ No ❑ Yes, see dates:	_____ through _____	_____ through _____

If there is any change in this coverage, please notify the county DHS office.

5. Discharge Data

Date of Discharge	Reason for Discharge
Last Month in Facility (for residents who transfer to another facility or level of care): _____ Days in facility _____ Reserve bed days _____ Non-covered days _____ Total billing days on claim to fiscal agent	❑ Died ❑ Transferred to another facility Name_____ Level of care, if known _____ ❑ Moved to new living arrangement Address, if available_____

Instructions for Preparing the Case Activity Report:

- When a current resident applies for Medicaid, complete Sections 1-3. Enter the first name, middle initial, and last name of the resident as they appear on the Medical Assistance Eligibility Card. The state ID number is assigned by the Iowa Department of Human Services and consists of seven digits plus one letter, e.g. 1100234G.
- When a Medicaid applicant or recipient enters the facility or changes level of care, complete sections 1-3, and section 4, if applicable.
- When a Medicaid applicant or recipient dies or is discharged, complete Sections 1 and 5.
- This form must be completed within 2 business days of the action.
- The administrator or designee responsible for the accuracy of this information should sign in Section 2. The date is the date the form is completed and sent to the county Department of Human Services office.

Distribution Instructions for RCFs

Mail the white copy to your county DHS worker. Keep the yellow copy. Discard the pink copy.

Distribution Instructions for NFs, ICF/MRs, SNFs, Mental Health Institutes and Psychiatric Medical Institutions for Children

Mail the white copy to your county DHS worker. Mail the yellow copy to IFMC. Keep the pink copy.

IFMC Address: Iowa Foundation for Medical Care
6000 Westown Parkway Ste 350
West Des Moines IA 50265

2. Instructions

Complete the *Case Activity Report* and submit it to the county Department office when:

- A current resident applies for Medicaid.
- A Medicaid-eligible resident.
  - Enters the facility
  - Changes level of care
  - Is discharged from facility
  - Dies

When a Medicaid applicant or recipient enters the facility, complete Sections 1-3 and, if applicable, Section 4. When a Medicaid applicant or recipient dies, complete Sections 1 and 5. Detailed instructions are given on the back of the form.

Note: Facilities no longer should send a *Case Activity Report* when a client enters or returns from the hospital or therapeutic leave to the same level of care. A discharge for the *Case Activity Report* does not mean someone who is transferred to the hospital with an expectation to return, even though they exceed the bed hold days for the month.

Within two business days of the action, mail the white copy to the county DHS office, mail the yellow copy to the Iowa Foundation for Medical Care. Keep the pink copy.

Section 1. Recipient Data: Section 1 contains resident-specific information. Use the recipient's first name, middle initial, and the last name as it appears on the *Medical Assistance Eligibility Card*. The "Date Entered Facility" is the date the resident entered the facility for the first time, or was readmitted to the facility following a discharge.

Section 2. Facility Data: Section 2 contains information on the facility and the person filling out the form (either the administrator or designee). Your provider number must match the level of care indicated in Section 3. The "DHS Per Diem" is the facility's computed rate. The "Date Completed" is the date the form is completed and sent to the county DHS office.

Section 3. Level of Care: Section 3 lists the level of care (ICF, skilled, etc.) the "Effective Date" as determined by the Iowa Foundation for Medical Care, Medicare, or the managed care contractor.

Section 4. Medicare Information for Skilled Patients in Skilled Facilities: Section 4 reflects Medicare coverage that may be applicable when a skilled resident is in a skilled nursing facility.

Section 5. Discharge Data: Fill out section 5 when a resident leaves the facility or dies. The income maintenance worker needs the information to calculate client participation for a partial month.

Provide information under "Last Month in Facility" only if the resident transfers to another facility or living arrangement (but not home).

E. Resident Financial Participation

Upon admission to the nursing facility or Medicaid approval, make any necessary arrangements for financial participation by the resident with a Medicaid-eligible person (or relatives, guardians, or trustees).

Vendor payments for nursing facility care are made to participating nursing facilities to supplement the resident's income. The resident keeps $30 of income for personal needs (plus a possible diversion for health insurance). The balance of income is applied to the cost of nursing facility care. It is the responsibility of the nursing facility to collect financial participation from the resident.

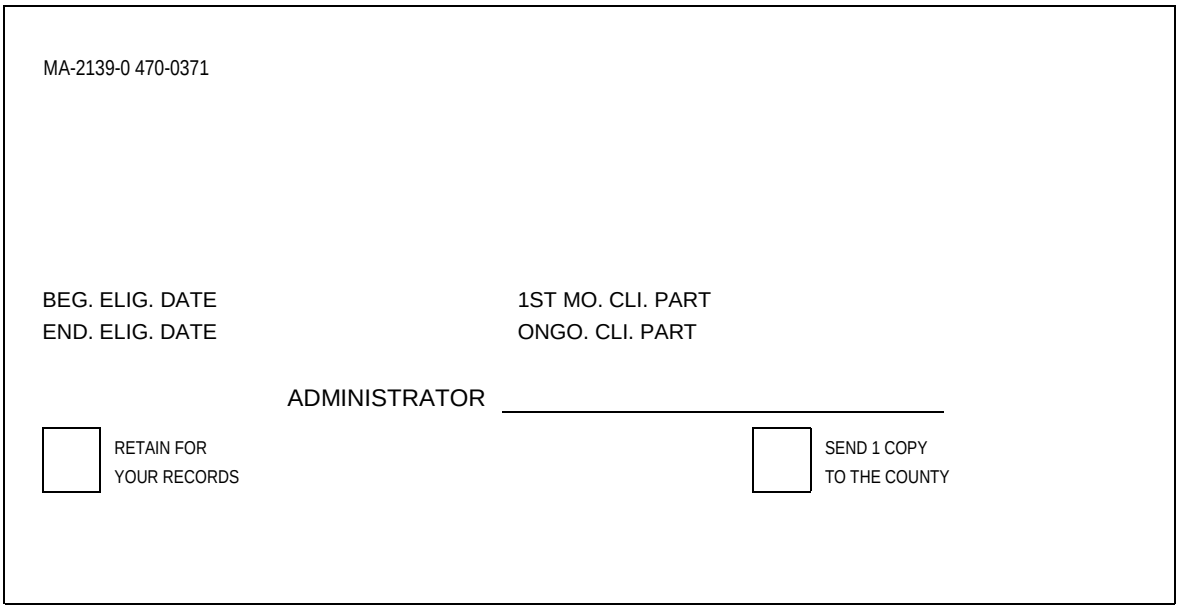
Sometimes diversion of the resident's income is allowed to a spouse who is not in the nursing facility. Such a diversion is allowed to bring the gross income of the spouse up to the SSI payment level for one person. If there is a spouse at home with dependent children under age 18, a diversion is allowed in the amount necessary to bring the gross income up to FIP standards for a family of the same size.

For client participation, the facility and the hospice must jointly determine who will collect the money. The contract between the nursing facility and the hospice provider must include a statement defining who is to collect the client participation.

1. *Facility Card*, MA-2139-0

Form MA-2139-0, *Facility Card*, is a computer form generated in two copies. It is initiated by the central office of the Department from information supplied by the county office income maintenance worker who determines financial eligibility for Medicaid.

The form indicates the first day for which payment may be made, the facility in which the recipient is residing, and the amount of the recipient's available income being applied to the cost of care (client participation).



MA-2139-0 470-0371

BEG. ELIG. DATE
END. ELIG. DATE

1ST MO. CLI. PART
ONGO. CLI. PART

ADMINISTRATOR _____

☐ RETAIN FOR YOUR RECORDS

☐ SEND 1 COPY TO THE COUNTY

Simultaneously with the sending of this form, a printout containing the person's financial eligibility information is sent to the Division of Medical Services. When this financial eligibility information is matched with medical approval information furnished by the IFMC, the resident's file is opened for nursing home payment.

Upon receipt of form MA-2139-0 for a resident:

1. Check the information on the form for accuracy. If there appears to be an error in the beginning eligibility date, the amount of financial participation, or any other item, contact the county Department office as soon as possible. The information shown on form MA-2139-0 is the basis for nursing payment to the facility.

2. Send one copy of this form to the county Department office. Keep the remaining copy as a facility record.

2. Personal Needs Allowance

All Medicaid residents of a nursing facility have a small monthly income which is intended to cover the purchase of necessary clothing and incidentals. This is called the personal needs allowance.

If the resident has personal income, the first $30 of income is retained for these personal needs and an additional amount up to $65 is allowed from earned income only.

If the resident's income is less than the personal needs allowance, the difference between the income and the personal needs allowance is usually paid to the resident through the Supplemental Security Income Program.

The personal needs allowance is as its name suggests: an allotment of money provided for the resident to spend on personal needs and articles as the resident wishes. No Medicaid resident or responsible party must be charged for items not specifically requested by the resident or responsible party.

The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

The resident should be the person who spends the money, and should be encouraged to see the money as personal funds. If the resident is unable to manage funds, the guardian should then use the allowance to meet the personal needs of the resident.

The personal needs allowance is one method of improving the quality of life for people needing a nursing facility living situation. The money can serve as a way for residents to maintain control over a segment of their personal life and environment and to individualize themselves in an institutional setting.

F. Periods of Service for Which Payment Is Authorized

Payment for care in a nursing facility is authorized as long as the resident is certified as medically needing that level of care and is otherwise eligible for Medicaid. Medicaid recipients must be in Medicaid-certified beds in order to receive payment from Medicaid.

If only a distinct part of the total facility has been certified as a nursing facility, Medicaid payment may be approved only for residents who occupy beds in the certified part of the facility. The facility cannot submit claims to the state nor request authorizations from the Department for residents who do not receive care in the certified part of the facility.

When a resident becomes eligible for Medicaid payments for facility care, the facility must accept Medicaid rates effective when the resident's Medicaid eligibility begins. When the beginning Medicaid eligibility date is a future month, the facility must accept the Medicaid rate effective the first of that future month. The beginning date of eligibility is given on the *Facility Card*.

A facility must refund any payment received from a resident or family member for any period of time when the resident is eligible for Medicaid. Any refund owing must be made no later than 15 days after the facility first receives Medicaid payment for the resident for any period of time. Facilities may deduct the resident's client participation for a month of Medicaid eligibility from the refund of the amount paid.

Payment is made for the day of admission but not the day of discharge or death. No payment will be made for care of persons entering and leaving the facility the same day. Days of absence with no Medicaid payment are billed as noncovered days. Facilities must maintain documentation on all reserve bed days for audit purposes.

1. Absence From Facility for Visits

The facility will be paid to hold the bed while the resident is visiting away from the facility for a period not to exceed 18 days in any calendar year. These 18 days may be taken at any time. There is no restriction as to the amount of days taken in any one month or on any one visit, as long as the days taken in the calendar year do not exceed 18.

Additional days will be allowed if the resident's physician recommends in the plan of care that additional days would be rehabilitative. The physician's recommendation should be available at the facility for audits. Visit days cannot be used to extend payment for hospital stays.

2. Absence From the Facility for Hospitalization

Payment will be approved to hold the bed while the resident is hospitalized for a period not to exceed ten days in a calendar month, as long as the resident intends to return to the facility and the facility has not discharged the resident. Payment will not be made for over ten hospital reserve bed days per month. Example:

A resident enters the hospital on September 21 and is discharged on October 14. The resident then reenters the hospital on October 18 and is discharged October 31.

For the first hospitalization, Medicaid will pay to hold the bed for the ten-day period of September 21-30. The ten days renew in October. Medicaid pays to reserve the bed for the period of October 1-10 (ten days). The period of October 11-14 and October 18-31 are not covered due to the ten-day limit in any one month.

Payment for reserving beds in nursing facilities is made only to those facilities where a resident was admitted before the absence. No payments are made to reserve a bed in a facility to which a resident intends to transfer. No payment is made to reserve a bed while a client is at the skilled or ICF/MR level of care or at a state mental health institute.

G. Continued Stay Reviews

Continued stay reviews for medical approval are the responsibility of the Iowa Foundation for Medical Care. Continued stay reviews are conducted no later than annually following admission. The purpose is to determine if the resident continues to need the nursing care.

Medicaid residents who meet the definition of "inactive review status" are not reviewed. The "inactive review status" is defined as a Medicaid resident who:

- Has resided in the facility for more than two years continuously, who is in stable condition; or
- Is 80 years of age or older and has been in the facility for one year or longer.

VIII. TRANSFER AND DISCHARGE

A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. The administrator and staff must assist the resident in planning for transfer or discharge through development of a discharge plan.

Transfer and discharge includes movement of a resident to a bed outside of the certified facility, whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

The following sections explain requirements for:

- A hospital transfer agreement.
- Notice of bed-hold policy and readmission.
- Allowable reasons for transfer and discharge.
- Discharge summaries.
- Administrative procedures when a Medicaid recipient is discharged from the facility.

A. Hospital Transfer Agreement

The facility must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs. The agreement must reasonably ensure:

- Residents will be transferred from the facility to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician.
- Medical and other information needed for care and treatment of residents will be exchanged between the institutions.

When the transferring facility deems it appropriate, information for determining whether the residents can be adequately cared for in a less expensive setting than either the facility or the hospital must also be transferred.

The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.

B. Notice of Bed-Hold Policy and Readmission

A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the Medicaid bed-hold period is readmitted to the facility.

If the resident requires the services of the facility and is eligible for Medicaid nursing facility services, the resident must be readmitted immediately upon the first availability of a bed in a semiprivate room.

Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility must provide written information to the resident and a family member or legal representative. The information must specify:

- The duration of the Medicaid bed-hold policy during which the resident is permitted to return and resume residence in the facility.
- The facility's policy about bed-hold periods.

At the time of a resident's transfer for hospitalization or therapeutic leave, the nursing facility must again provide this written notice to the resident and a family member or legal representative.

C. Allowable Reasons for Transfer or Discharge

The facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless:

- The transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility.
- The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.
- The safety of persons in the facility is endangered.
- The health of persons in the facility would otherwise be endangered.
- After reasonable and appropriate notice, the resident has failed to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.
- The facility ceases to operate.

Except when the transfer is due to the closing of the facility, the facility must document the reason for the transfer in the resident's clinical record. The reasons for transfer or discharge must be recorded before the resident is moved.

When the transfer is due to the resident's health improving or failing, the documentation must be made by the resident's physician. When the transfer is due to endangerment of other residents, the documentation must be made by a physician.

D. Notice Requirements for Transfer or Discharge

Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move. The notice must be in writing and in a language and manner the resident and family member understand.

The facility must make the notice at least 30 days before the resident is transferred or discharged. **Exception:** Notice must be made as soon as practicable before transfer or discharge when:

- The safety of persons in the facility would be endangered.
- The health of persons in the facility would be endangered.
- The resident's health improves sufficiently to allow a more immediate transfer or discharge.
- An immediate transfer or discharge is required by the resident's urgent medical needs.
- A resident has not lived in the facility for 30 days.

The written notice must include:

- The reason for transfer or discharge.
- The effective date of transfer or discharge.
- The location to which the resident is transferred or discharged.
- A statement that the resident has the right to appeal the action to the Department.
- The name, address, and telephone number of the state long-term care ombudsman.
- The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled persons, for residents with developmental disabilities.
- The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals, for residents who are mentally ill.

When a public assistance recipient requests transfer or discharge, or another person requests this for the recipient, the administrator must promptly notify the Department's county office. This must be done in sufficient time to permit a social service worker to assist in the planning for the transfer or discharge.

A facility that plans on closing must notify the Department at least 60 days in advance of the closing. Plans for the transfer of residents receiving Medicaid must be approved by the Department's county office.

E. Discharge Summary

When the facility anticipates discharge, a resident must have a discharge summary that includes:

- A recapitulation of the resident's stay.
- A final summary of the resident's status at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.
- A postdischarge plan of care developed with the participation of the resident and resident's family which will assist the resident to adjust to a new living environment.

When a resident is transferred to another facility, transfer information must be summarized from the facility's records in a copy to accompany the resident. This information must include:

- A diagnosis.
- Activities of daily living information.
- Transfer orders, a nursing care plan.
- The physician's order for care.
- The resident care review team assessment.
- The resident's personal records (including the personal needs fund record when applicable).

F. Administrative Procedures

If a Medicaid recipient requests transfer or discharge, or there is another person requesting this for the resident, the nursing home administrator must promptly notify the county office of the Department by means of 470-0042, *Case Activity Report*. (See Item VII.D.)

This should be done within two days of the action. This will allow the county office enough time to complete the necessary paperwork, ensuring a smooth discharge or transfer for the resident.

When the county office receives a *Case Activity Report* stating that a resident has been discharged (through death, return to own home, etc.), the income maintenance worker closes the Medicaid nursing facility case through the computer system. This information is forwarded to the Departments' central office. A form MA-2139-0 is generated to verify the action. (See Item VII.E.)

The facility must refund any unused client participation. See Item IX.D.4 for more information. When a resident is transferred to another Medicaid facility, the income maintenance worker enters the necessary information concerning the transfer. This information generates another form MA-2139-0, which is sent to the gaining facility.

If the transfer is between counties, the income maintenance worker transfers the case. The income maintenance worker in the county to which the resident transfers completes the action.

The following sections explain policies on:

- Transfer of residents by ambulance.
- Handling personal needs funds on the death of a resident.

1. Transfer of Residents by Ambulance

In some emergency cases, such as a facility's closing or loss of Medicaid certification, residents must be transferred from one facility to another by ambulance. Arrangements can be made to pay for this service through the Medicaid program.

When a resident is transferred by ambulance, a worker from the Department county office will provide the Medicaid fiscal agent with the information necessary to process the claim and authorize the fiscal agent to make payment. Close coordination between the Division of Medical Services, county offices, and facilities is required in all emergency situations.

2. Transfer of Personal Needs Funds After Death of Resident

Upon a recipient's death, a receipt must be obtained from the next of kin, the resident's guardian, or the representative handling the funeral before releasing the balance of the personal needs funds.

In the event there is no next of kin or guardian available and there is no outstanding funeral expenses, any funds must revert to the Department. In the event that an estate is opened, the Department must turn the funds over to the estate.

IX. BASIS OF PAYMENT

Nursing facilities are reimbursed under a cost-related vendor-payment system with a per diem rate set for each facility. This rate is established on the basis of financial and statistical data submitted semiannually by the facility on form 470-0030, *Financial and Statistical Report*.

When the completed *Financial and Statistical Report* is received in the Department, the information it contains is used to recompute the individual facility's rate. The base payment rate is the facility's audited cost or the maximum allowable per diem rate (whichever is less).

Payment for care in a nursing facility is made on a per diem basis for the portion of the month the resident is in the nursing facility. Medicaid payments for nursing facility care are made to supplement the resident's income. After the resident's financial participation is exhausted, the state makes up the difference between the resident's income and the allowable cost of nursing facility care.

The following sections explain:

- Calculation of a facility's Medicaid reimbursement rate.
- Allowable costs for facility payment.
- Use of resources available to the resident.
- Requirements for completing cost reports.

A. Reimbursement Rate

Except for RCFs and RCF/MRs that have chosen to receive a flat per diem rate, facilities are reimbursed under a prospective cost-related payment system. A per diem rate is established for each facility on the basis of financial and statistical data which the facility submits. This financial data is audited by the accounting firm on contract with the Department, Ryun, Givens, Wenthe, Inc.

The facility's costs (or the maximum allowable costs as determined by the Department or its agent) are used as the base payment rate. As allowed by legislative action and Department rules, an inflation factor and an incentive factor are added to the base rate (excluding the portion attributable to interest charges) to help compensate for rising costs.

The new rate is subject to the ceilings determined by the Department. The maximum allowable cost is determined annually by the legislature at a level where a specified percentage of participating facilities are receiving 100% of allowable costs. Each year the Department notifies facilities of these rates by sending an informational letter.

The review process will be completed within the two months after the reports are received by the Department. Payments at the new rate are effective with services rendered on the first day of the month in which the reports were received. A retroactive payment adjustment will be included with the payment prepared the third month after receipt of the form. Example:

Facility XYZ has a fiscal year ending 12/31/98.
The facility submits a cost report 1/16/99.
The Department receives the report 1/17/99.
The Department's agent receives the report 1/18/99.

The report is processed and returned to the Department on 3/29/99 with new rate computed.

The new rate becomes effective with services rendered 1/1/99. The adjustment is included with the payment forwarded to the facility on or about 4/22/99.

The Department will pay the calculated payment rate (subject to the maximum allowable cost ceiling), and the facility must accept it as payment in full. (In the State Supplementary Assistance program, the Department pays the resident, who uses the Department payment to supplement the resident's direct payment to the facility.)

1. Rate Determination

The Department establishes the reimbursement rate for each facility by determining, on a per diem basis, the allowable cost plus the established inflation factor, plus the established incentive factor, plus a possible case mix factor.

For non-state-owned facilities, an additional factor in determining the reimbursement rate is arrived at by dividing total reported patient expenses by total patient days during the reporting period. A "patient day" is that period of service rendered a patient between the census-taking hours on two successive days. The day of discharge is counted only when the patient was admitted the same day.

For purposes of the computation of patient care service expenses, "patient days" are inpatient days as defined above. For purposes of the computation of all other expenses, "patient days" are inpatient days as as defined above or 80 percent of the licensed capacity of the facility, whichever is greater

Nursing facilities and RCFs are subject to a maximum allowable cost. New ICFs/MRs are subject to a maximum allowable rate for their first six months of operation.

The other factors affecting rate determination are defined as follows:

- **Inflation factor.** An inflation factor is considered in determining the facility's prospective payment rate. The factor is determined by using the change in the weighted average cost per diem of the compilation of various costs and statistical data, as found in the two most recent reports of "Unaudited Compilation of Various Costs and Statistical Data."

  The percentage increase of this weighted average is the basis for the next annual inflation factor. This factor must not exceed the amount established by the legislature.

- **Transitional case-mix factor.** The case-mix factor is a semi-annual weighting factor added to the Medicaid reimbursement rate which is based on the acuity and care need level of residents of a nursing facility. The factor must not exceed the amount established by the Iowa Legislature for the transitional case-mix period

  Each facility's case-mix index is derived from MDS reports.

  - Tier 1: Facilities with a case-mix index that exceeds the Iowa nursing facility average and patient care service costs that exceed the average for all participating nursing facilities will receive an additional payment to their daily payment rate, notwithstanding the maximum payment rate.
  - Tier 2: Facilities with a case-mix index that exceeds the Iowa nursing facility average and patient care service costs which are less than the average for all participating facilities will receive an addition to their payment rate equal to one-half of Tier 1, notwithstanding the maximum payment rate.

- **Incentive factor.** An incentive factor is determined at the beginning of the state's fiscal year, based on the most recent report of "Unaudited Compilation of Various Costs and Statistical Data."

  The incentive factor is equal to one-half the difference between the forty-sixth percentile of allowable costs and the seventy-fourth percentile of allowable costs. However, under no circumstances can the incentive factor be less than $1 per patient day or more than $1.75 per patient day.

a. New Facility or New Construction

Facilities for which costs have not been established include:

- A facility opened for operation for the first time (building an entirely new clientele).
- A facility that moves residents from an old building to a newly constructed building with the same owner.

New RCFs and NFs will receive the prevailing maximum allowable cost ceiling, not to exceed private-pay charges. New ICFs/MR are subject to a maximum rate set at the 80th percentile of all participating facilities.

*Financial and Statistical Report*s stating actual costs must be submitted as follows:

Facility type	First Report of Actual Costs	Subsequent Reports
Nursing facility	After 3 months' operation	Six months later or at the end of the fiscal year, whichever is earlier, and every 6 months thereafter.
ICF/MR	After 6 months' operation	After second 6 months' operation. After third 6 months' operation ending June 30. It may be necessary to include months previously reported or to supply a fourth report in order to provide a 6-month report ending June 30. Every 12 months thereafter (ending June 30).
Residential facility	After 3 months' operation	At the end of the facility's fiscal year and every 12 months thereafter.

b. Multilevel Facility

If there are different levels of care in a facility, the facility may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. The Department may require a cost apportionment schedule if deemed necessary for a fair presentation of expense attributable to that facility's residents.

The report is designed to accommodate multilevel facilities by providing space to allocate costs to the various programs, as well as an explanation of the allocation method employed. It accommodates all levels of care.

For facilities which have service programs funded through a purchase of service contract or through other funding mechanisms, it is essential that costs are allocated properly to these programs and that the same costs are not included in cost reports for more than one program.

For Medicaid hospice services, facilities should report room and board days. Each facility should report the amount of revenues paid by the hospice agency to the nursing facility for reimbursement for the room and board of those residents participating in the hospice program. For instructions on reporting, please see the instructions for Schedule A.

To provide respite care for clients living in their own home and eligible for a home- and community-based waiver, the facility must enroll as a waiver provider through the Medicaid fiscal agent. The facility will be paid its usual Medicaid rate for the respite care if respite is the plan of care approved for the client by the county Department service worker or case manager.

c. Existing Facility Sold to New Owner

When an existing facility is sold to a new owner, the new owner must continue with the previous owner's per diem rate until a new *Financial and Statistical Report* has been submitted and a new rate established.

The new owner may:

- Submit a report for the period from the beginning of actual operation to the end of the facility's fiscal year, or
- Elect to submit two cost reports within the initial fiscal year, provided the second report covers a period of six months ending on the last day of the fiscal year.

The initial reporting period must include at least three months of activity. The facility must notify the Department of the reporting option selected.

2. Comparison With Private Pay Rates

The Department will not pay facilities a per diem rate in excess of the average per diem rate charged to private-pay residents. The nursing facility must compute the average per diem rate for private-pay clients on a facility-wide basis twice yearly. This computation must coincide with the preparation of the *Financial and Statistical Report,* form 470-0030, and shall be reported as the last item on Schedule A.

To compute the average private-pay rate, accumulate the total monthly charges for all private-pay residents for the six-month period. Divide this sum by the total patient days for all private-pay residents for the same period. This produces the private-pay average per diem rate for the entire facility.

Total monthly charges for private-pay residents include the basic charge, for example, $35.00 per day, plus standard charges for extra care and services, for example, $8.00 per day.

In nursing homes, this additional charge might include such services as assistance in dressing, bathing, and feeding. Other additional charges might be for medical supplies such as chux, incontinence pads, dressings, disposable sterile nursing supplies, laundry service, air conditioners, television, medications, lubricants, rubbing compounds, physical therapy, hypodermic syringes and needles, wheelchairs, walkers, crutches, and canes.

If the computation reveals that the average private-pay per diem is lower than the rate being paid for public assistance recipients, the administrator or the owner must notify the Department of the difference as soon as it becomes evident. The facility must then arrange to receive the lower rate in payment for public assistance recipients.

The facility must keep the working papers used in arriving at the average private-pay per diem with other financial and statistical records. They must be made available to authorized representatives or agents of the Iowa Department of Human Services and the U.S. Department of Health and Human Services upon request.

3. Payment Rate for Reserved Beds

Medicaid payments for reserved days are made at the rate of 75 percent of the actual per diem rate, but not to exceed the maximum rate.

(Actual per diem rate = facility costs + any added factors. This is the per diem rate that the facility would receive if there were no ceiling on the rate allowable for nursing facility care.)

The 75 percent payment rate also applies to residents and others paying to reserve beds for residents absent from facilities past the cutoff date for Medicaid payment. (See Item VII.F, **Periods of Service for Which Payment Is Authorized**, for an explanation of the cutoff date.)

A facility may not collect more client participation than the Medicaid program would have paid for the service. Since the 75 percent payment rate affects the use of the client participation, administrators must ensure that the correct amount of financial participation is collected. This is particularly important where a resident leaves the facility and is due a refund on financial participation previously collected.

4. Out-of-State Care

Payment may be made for care of Iowa residents in nursing facilities in states which border Iowa. These facilities must have a contract with the Department of Human Services in order to receive payments through the Iowa Medicaid Program.

The reimbursement to out-of-state providers will be the rate paid by the state where the provider is located, subject to the Iowa maximum. The Department of Human Services will contact out-of-state agencies semiannually to ascertain that out-of-state facilities are being paid at the proper rate. When rates are changed, the Department will make adjustments as necessary.

B. Allowable Costs for Facility Payment

A facility's per diem rate is intended to cover all normal costs of operating a nursing care facility. Included are:

- Fixed operating costs.
- Building and medical equipment.
- Salaries.
- Disposable supplies.
- All services provided to residents.

A facility must accept the per diem rate set by the Department as payment in full for all services and supplies required by a Medicaid resident, unless the services or supplies are otherwise paid through Medicaid. No additional charges can be made to a resident or resident's family for any services related to the resident's care.

It is not possible to foresee all items which may be considered to be either allowable or unallowable expenses. Unusual, one-time only, or infrequently claimed expenses may need to be submitted for a determination of allowability when they occur.

The following sections give more information on charges for:

- Legend drugs.
- Other drugs and supplies.
- Special services.
- Oxygen.
- Transportation to receive medical care outside the community.

1. Legend Drugs

No payment will be made to a nursing facility for legend drugs and insulin. Payment for legend drugs requiring a prescription by law will be made only to the licensed retail pharmacy of the recipient's choice.

Exception: This requirement does not apply to nursing facilities having a retail pharmacy license. In those facilities, payment will be approved for drugs provided and billed for by the facility.

Pharmaceutical records with reference to Medicaid recipients must be maintained according to regulations for pharmaceutical services in the Medicaid Program. Refer to the Medicaid Provider Handbook for Prescribed Drugs for details and billing procedures.

2. Other Drugs and Supplies

The cost of nonlegend drugs (i.e., those which may be purchased from a retail pharmacy without a physician's prescription) and medical and sickroom supplies must be included in the costs of the nursing facility that are used in establishing the per diem rate.

No Medicaid payment normally will be made to a retail pharmacy for nonlegend drugs or medical and sickroom supplies for a resident in a nursing facility, except for oxygen and some nonlegend drugs. An illustrative list of the items is included in the instructions for Schedule A of the *Financial and Statistical Report.*

3. Special Services

In general, all services called for in the plan of care for a resident which are related to the residents' physical or psychosocial functioning must be included as costs of operation (audit costs). This includes both:

- Health-related services (such as reality therapy, rehabilitation programs, and temporary private duty nursing).
- Such things as expanded recreation and activities programs.
- All costs related to securing these services.

If there is a question about the appropriateness of including a particular service among the costs of operation, contact the Bureau of Health Care Purchasing and Quality Management with the Division of Medical Services.

4. Oxygen

Medicaid will provide payment to medical equipment and supply dealers to provide oxygen services in a nursing facility when all of the following requirements and conditions have been met:

- A physician's prescription documents that a resident of a nursing facility requires oxygen for 12 hours or more per day.
- The provider and physician jointly submit HCFA form (A-484), *Physician's Certification of Medical Necessity for Home Oxygen Therapy*, or a reasonable facsimile to the Medicaid fiscal agent with the monthly billing. The documentation submitted must contain the following:
  - The diagnosis and prognosis of the disease requiring continuous oxygen.
  - The length of time the oxygen will be needed.
  - The type of system ordered, i.e., cylinder gas, liquid gas, or concentrator.
  - The number of hours oxygen is required per day.
  - A specific estimate of the frequency and duration of use.
  - The oxygen flow rate and concentration.
  - Where applicable, the initial reading on the time meter clock on each concentrator.
- The provider maintains oxygen logs. When random postpayment review of these logs indicates less than an average of 12 hours per day of oxygen was provided over a 30-day period, recoupment of the overpayment may occur.

The maximum Medicaid payment is based on the least costly method of oxygen delivery. Payment will be made for only one mode of oxygen even if the physician's prescription allows for multiple modes of delivery.

Medicaid payment are made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system, including servicing and repairing of equipment, are included in the Medicaid payment.

5. Transportation to Receive Medical Care Outside the Community

Payment will be approved for transportation to receive services covered under the Medicaid program only to the nearest institution or practitioner having appropriate facilities for care of the recipient when both of the following conditions are met:

- The recipient needs the transportation because:
  - The source of the care is located outside the city limits of the community in which the recipient resides, or
  - The recipient resides in a rural area and must travel to a city to receive necessary care, or
  - The type of care is not available in the community in which the recipient resides, or
  - The recipient has been referred by the attending physician to a specialist in another community.
- There is no resource available to the recipient through which necessary transportation might be secured free of charge.

Transportation may be of any type and may be provided from any source. When transportation is by car, the maximum payment is the actual charge made by the provider for transportation to and from the source of medical care, but not in excess of the rate per mile payable to state employees for official travel.

When public transportation is used, the basis of payment is the actual charge made by the provider of transportation, not to exceed the charge that would be made by the most economical available source of public transportation.

Public transportation must be used in all cases where it is reasonably available to or from the source of care and the recipient's condition does not preclude its use. When the recipient's condition precludes the use of public transportation, a statement to that effect must be included in the case record.

When a child is too young to travel alone, or an adult or child is unable to travel alone because of physical or mental incapacity, payment will be made for the transportation costs of an escort, subject to the above conditions. The county DHS worker is responsible for making a decision concerning the necessity of an escort and recording the basis for the decision in the case record.

When meals and lodging or other travel expenses are required in connection with transportation, payment is subject to the same conditions as for a state employee.

6. Supplementation

Medicaid rules prohibit supplementation of the Medicaid payment for care in a nursing facility. Only the amount of client participation may be billed to the resident. No supplementation of the state payment can be made by any person.

Practices such as charging residents or their families extra money for a private room or transportation to and from a doctor are considered to be supplementation and are not permissible, even if the payment is offered voluntarily.

Exceptions:

- During **absences** from the facility, the resident or someone acting on behalf of the resident may pay the facility to hold the resident's bed beyond the cut-off date of the Medicaid payment.

  For example, if a resident is in the hospital longer than ten days, the resident or a person acting on the resident's behalf may pay to hold the resident's bed if they so desire. Facilities are responsible for making arrangements with residents for reserving beds in advance of the date when the resident will be billed for the bed.

  In no case can a Medicaid resident or a person acting in the resident's behalf pay the facility a higher rate for reserving a bed than what would be paid by the Medicaid program. No payments may be made by a resident, or someone acting on behalf of the resident, for a period which is covered by Medicaid payment.

- There are cases when a family member or other interested person wants to make an ongoing **voluntary contribution** toward the cost of care of a Medicaid resident.

  Such payments will not be considered as supplementation, so long as they increase the resident's client participation and are not over and above the payment made by the state for care of the resident. Form 470-0373, *Voluntary Contribution Agreement*, may be used to implement such a voluntary contribution. A facsimile of this form follows.

  The contributor must contact the income maintenance worker at the county DHS office to initiate the form. The form must be signed by the contributor, the facility administrator or representative, and a Department representative. The form, completed in three copies, is retained by the contributor, the nursing facility, and the county DHS office.

Iowa Department of Human Services

VOLUNTARY CONTRIBUTION AGREEMENT

1. I _____, agree to contribute $ _____ monthly toward the care of _____, a Medicaid resident of _____, a health care facility located in _____. This contribution will be furnished to the facility no later than the _____ day of each month. I understand that this contribution is completely voluntary. I am making it with the understanding that I may terminate or change the amount of contribution at any time I so desire. If I decide to terminate or change the amount of my contribution, I will notify the facility of my intentions.

Name
Address

2. I understand that the voluntary contribution stated in paragraph 1 is to be considered as financial participation toward the basic cost of the care of the resident designated and that if such contribution ceases, or changes in amount, the local office of the Department of Human Services will be promptly notified.

Administrator or Representative
Facility
Address

3. I understand that the amount of voluntary contribution stated in paragraph 1 is to be considered as financial participation toward the care of the resident named until notified otherwise. Upon notification of any change in the amount of contribution, such information will be promptly forwarded to the Quality Assurance Section of the Department of Human Services and, if applicable, a new letter of Agreement will be initiated.

Department of Human Services Representative
Local Office

C. Use of Resources Available to the Resident

Medicaid payments for nursing facility care are made to supplement the resident's income. After the resident's financial participation is exhausted, the state makes up the difference between the resident's income and the cost of nursing facility care. The facility is responsible for collecting the resident's financial participation.

1. Medicare, Veterans, and Similar Benefits

All medical resources available to the resident must be used. Such resources include:

- Private health or accident insurance carried by the resident or by others on the resident's behalf, and
- Services reasonably available through other publicly supported programs, such as Medicare, Veterans Administration, Vocational Rehabilitation, etc.

When a facility receives information that not all resources available to a resident are being used, the facility should inform the county DHS office in writing. Following is a suggested format:

> We have received information that this resident may:
>
> - Be eligible for veterans benefits.
> - Have other potential resources to pay for nursing care as described below.
> - Not be eligible for Medicaid because.

2. Client Participation

All of a resident's income in excess of authorized exemptions is applied toward the cost of nursing care. This includes interest earned on the resident's personal needs funds.

A nursing facility may not charge more client participation for Medicaid-eligible clients than the maximum monthly allowable payment for the facility. When the Department makes a retroactive increase in the maximum daily rate, the nursing facility can charge the client the increased amount for the retroactive period.

Client participation begins with the first month of admission as a Medicaid resident in the following instances:

- Residents leaving the facility for hospitalization or to a skilled level of care who remain on the Medicaid program and later return to the nursing facility.
- Medicaid-eligible persons transferring from residential care to nursing facility care.
- Residents changing from private pay status to Medicaid status while residing in a nursing facility.
- Residents transferring from an out-of-state nursing facility to an Iowa facility.

A resident who has moved from an independent living arrangement to a nursing facility may have limited first-month client participation due to maintenance or living expenses connected with the previous living arrangement. The county DHS office determines how much of the resident's income may be protected to defray expenses and how much is available for first-month client participation.

If a resident transfers from one nursing facility to another during a month, any remaining financial participation must be taken to the new facility and applied to the cost of care at that facility.

Present policy concerning reserve bed days has the result of changing financial participation in some cases when residents are absent from the facility. (See section IX.A.3, **Payment Rate for Reserved Beds**.) Administrators should ensure that the correct amount of financial participation is collected, particularly in cases where the resident may transfer from the facility.

The amount of ongoing financial participation is shown on form MA-2139-0, *Facility Card*. See section VII.E, **Resident Financial Participation**.

3. Refund of Unused Client Participation

When a resident leaves the nursing facility during the month, any unused portion of the resident's income must be refunded. The following example illustrates the procedure used in calculating refunds due the resident:

> Mr. S has a monthly Social Security income of $630. His only allowable deduction is for personal needs, so he has $600 to apply towards the cost of his care in the facility ($630 minus $30 personal allowance).
>
> The nursing facility in which Mr. S lives has a per diem rate of $75. In a normal month, Mr. S pays for the first eight days of his care ($75 x 8 days = $600) and the state pays for the remainder of the month.
>
> If Mr. S leaves the nursing facility on the 6th of the month, the facility must make a $225 refund to Mr. S ($600 minus $375 (5 days care) = $225). If he leaves the home on the 9th of the month or later, no refund would normally be due. (An exception could arise if reserve bed days are involved.)

4. *Adjustment to Facility Payment,* 470-0041

The county office income maintenance worker uses form 470-0041, *Adjustment to Facility Payment*, to correct errors in client participation which have caused overpayments or underpayments to a facility. (If the error is discovered before the facility billing cycle, it can be corrected without using this form.)

A facsimile of this form follows. Most of the items on the form are self-explanatory.

The beginning adjustment date is the start of the month in which the incorrect client participation was used, and the ending adjustment date is the end of the month in which the adjustment is required.

When the amount of the client participation is the same for more than one month, all months can be combined on one line. When the amount differs, different lines must be used.

A copy of the form is mailed to the facility to verify that the correction has been submitted. Monitor these reports and the resulting billings. Report any discrepancies to the resident's income maintenance worker.

Iowa Department of Human Services

ADJUSTMENT TO FACILITY PAYMENT

TO: Quality Assurance 1st Fl
1305 E Walnut
Des Moines IA 50319-0114

CC: Facility (enter address below)

fold line fold line

Provider	ICF/MR/RCF	Skilled	County Number:

Recipient SID Number	Recipient Name	Begin Adj. Date MM/DD/YY	End Adj. Date MM/DD/YY	Level of Care	Current CP Amount	New CP Amount
					$	$
					$	$
					$	$
					$	$
					$	$

If the first month CP is different than the other month, make a separate entry for the first month only. Other months that have the same CP can span several months for one entry.

APPROVED:

IM Worker	Worker Number	County
Phone	Extension Number	Date

Copy 1: QA Copy 2: Facility Copy 3: Case file

470-0041 (Rev. 2/00)

D. Facility Cost Report and Instructions

The *Financial and Statistical Report*, form 470-0030, is designed to provide information concerning costs of providing care to residents of the following types of facilities:

- Nursing facilities (NFs) participating in the Medicaid program.
- Intermediate care facilities for the mentally retarded (ICF/MRs) participating in the Medicaid program.
- Residential care facilities (RCFs) participating in the State Supplementary Assistance program.
- Residential care facilities for the mentally retarded (RCF/MRs) participating in the State Supplementary Assistance program.

Nursing facilities submit the report twice a year. After the required six-month reports have been submitted to establish the June 30 year end, the non-state-owned ICFs/MR submit reports annually for the period of July 1 through June 30. (State-owned ICFs/MR submit semiannual cost reports. RCFs and RCFs/MR submit form 470-0030 at the close of the facility's established fiscal year.)

The form consists of the Certification page and Schedules A, B, C, D, D-1, E, F, G, and H. You must furnish all information called for in the Schedules, unless you can show that it is not applicable to your operation.

The Department sends out copies of the form for the initial report and the first report of actual costs. After that, you may order form 470-0030 from Anamosa if you do not have your own approved computer version. A letter of notification is forwarded to each participating facility before the end of each reporting period.

If you change fiscal years, you must notify the Department 60 days in advance of the change. A facility may not change fiscal years more often than every two years. If you change your fiscal year within two years, you must submit cost reports on the previous fiscal year schedule until you meet the two-year limit.

Base the financial information on the audited financial statements, if applicable. Adjustments converting reported amounts to the accrual basis of accounting are required if the records are maintained on another accounting basis.

Submit the report to the Department no later than three months after the close of each reporting period. Submitting the report early is usually to the facility's best interest. Forward the original and one copy, both having original signatures of an officer of the facility, to:

Ryun, Givens, Wenthe and Company
1601 48th Street, Suite 150
West Des Moines IA 50266-6756

Failure to submit the report within the three-month period will reduce the payment to 75% of the current rate. This reduced rate will be paid for no longer than three months. After that, the state will make no further payments under Medicaid or State Supplementary Assistance if the report is not submitted.

Facilities must maintain form 470-0030 and all financial and statistical records to support the cost reports for a minimum of five years. Facilities are required to make these reports and records available to authorized representatives or agents of the Department and of the United States Department of Health and Human Services, upon request.

In these instructions, both of these programs are referred to as "public assistance" programs. Persons whose care is paid for in part by one of these programs are called "public assistance residents."

The standards for what is included in facility services differ between the Medicaid and State Supplementary Assistance Programs. In general, State Supplementary Assistance facilities are not required to provide medical care, supplies, or equipment for their residents. In many cases, Medicaid facilities are required to do so as part of the basic services offered by the facility.

Because of this and other differences in program rules, some instructions are labeled as applying specifically to NFs and ICF/MRs or to RCFs and RCF/MRs. Any questions about the difference in standards for these two programs should be addressed to the Division of Medical Services.

1. Facsimile of *Financial and Statistical Report,* Form 470-0030

Iowa Department of Human Services

FINANCIAL AND STATISTICAL REPORT

Facility Name	Federal ID Number	Vendor Number	
Street	City	State	Zip
Period of Report From To	Fiscal Year Ending Mo Day Year		County
Date Facility Entered Program	Date Owner Acquired Facility		

Type of Control (check only one)

GOVERNMENT
- ❑ State
- ❑ County
- ❑ Other

NONPROFIT ORGANIZATION
- ❑ Church-Operated
- ❑ Church-Related
- ❑ Other Nonprofit

PROPRIETARY
- ❑ Individual
- ❑ Partnership
- ❑ Corporation
- ❑ "S" Corporation

Accounting Basis: ❑ Accrual ❑ Modified Cash ❑ Cash

Ownership Information

Name of Owner	% of Work Week Devoted to Business	Title	Salaries and Wages	Social Security Number	% of Ownership in Home

NOTE: Attach additional schedules as necessary to complete ownership information.

Number of Medicaid Recipients at End of Period_____

Statistical Data

	# Authorized Beds Beginning Period	# Authorized Beds End of Period	Total Bed Days Reporting Period	Total Patient Days Reporting Period	Percent Occupancy Col. 4 ÷ 3	Number of Admissions	Number of Discharges
NF							
RCF							
SNF							
ICF/MR							
RCF/MR							
Total							

An opinion of a certified public accountant of the fairness of presentation of operating results or revenues and expenses (is, is not) attached. Questions concerning financial data included in this report should be directed to:

_____ Telephone (_____)_____

Certification Statement

Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and imprisonment under state or federal law.

I CERTIFY that I have read the above statement and that I have examined the accompanying cost report and supporting schedules. To the best of my knowledge and belief, it is a true and complete statement prepared from the records of the provider in accordance with applicable instructions. I further certify that costs have been properly allocated between or among programs and that no cost has been reported more than once as a reimbursable cost.

Signature of Officer or Administrator of Facility	Date

Facility	Vendor No.
Period of Report: From	To

SCHEDULE A

REVENUES	GENERAL LEDGER	ENTER IN COLUMN 2, SCHEDULE C	
		Adjustment Amount	Line(s) #
RESIDENT REVENUE CENTERS:			
Routine daily service			
Pharmacy, drugs and medications			73
Medical supplies			68
Laboratory			75
X-Ray			74
Occupational therapy			57
Physical therapy			57
Professional care, physician			96
Beauty, barber shop			90
Personal purchases for residents			91
Activities			
OTHER REVENUE CENTERS:			
Revenue from meals sold to guest and employee			72
Rental income			
Income of telephone charges paid by residents, guests and employees			10
Purchase discounts, if recorded			
Revenues from supplies employees			
Rebates			
Religious income			
Investment income. See instructions.			85
Other			
Average Private Pay Rate			
GROSS REVENUE			
DEDUCTIONS FROM REVENUE:			
Free care and allowances			
Provision for uncollectable accounts			
TOTAL DEDUCTIONS			
NET REVENUE (1)			

(1) Net revenue amount also must be entered on Schedule F, Reconciliation of Equity.

Facility	Vendor No.
Period of Report: From	To

SCHEDULE B

EXPENSE ADJUSTMENTS			ENTER IN COLUMN 3, SCHEDULE C	
			Adjustment Amount	Line(s) #
NONREIMBURSABLE EXPENSES:				
Provisions for income tax				92
Fees paid Board of Directors				94
Nonworking officers' salaries				95
Travel and entertainment. See instructions.				16
Donations				97
Expenses of nonparticipating facilities				
Fund-raising expenses				
Pharmacy, drugs, and medications				73
Insurance premiums on life of officer, owner				93
Other expenses not related to resident care				
EXPENSE LIMITATIONS:				
Salaries of owners and related parties. See instructions.				
Position	**Paid**	**Allowable**		
Administrator	$	$		1
Assistant administrator				2
Management fees				13
Nursing director				40
Other				
Services, facilities, supplies furnished by organizations related to the facility by common ownership or control				
	Paid	**Allowable**		
Rental equipment	$	$		
Services and supplies (describe)				
Rental of facility. See instructions.	(1)	(2)		
Payments				
Lessor's cost:				
Depreciation				
Interest				
Property tax				
Other				
Return on equity				
Reduction - Column 1 less than column 2				84
Advertising expense in excess of the lesser of $3,600 or an amount computed at 2% of routine daily revenue				17
Allowable depreciation from Schedule D and D-1				81
Interest expense on loans from partners, proprietors, stock-	**Expense**	**Allowable**		
holders, or related organizations. See instructions.	$	$		85

Facility	Vendor No.
Period of Report: From To	

SCHEDULE B

EXPENSE ADJUSTMENTS (Cont.)			ENTER IN COLUMN 3, SCHEDULE D	
			Adjustment Amount	Line(s) #
EXPENSE ADDITIONS: Compensation of nonsalaried proprietors and partners or members of religious orders	**Paid**	**Allowable**		
Administrator	$	$		1
Nursing director				40
Other				
TOTAL				

Note: Enter adjustments on Schedule C on the line for the expense center affected.

Facility	Vendor No.
Period of Report: From	To

SCHEDULE C - PART 1

Line	EXPENSES	1 Expenses per General Ledger	2 Adjustment of Expenses Schedule A	3 Adjustment of Expenses Schedule B	4 Resident Expenses
	ADMINISTRATIVE COSTS (1)				
1	Administrator wages				
2	Business office wages				
3	Employer's taxes (Admin.)				
4	Group health, life, and retirement benefits (Admin.)				
5	Worker's comp. insurance (Admin.)				
6	Employment advertising and recruitment (Admin.)				
7	Criminal record checks (Admin.)				
8	Education and training (Admin.)				
9	Supplies (Admin.)				
10	Telephone				
11	Equipment rental (Admin.)				
12	Home office costs				
13	Management fees				
14	Accounting costs, legal, and other professional fees				
15	General liability insurance				
16	Travel, entertainment, and auto				
17	Advertising and public relations				
18					
19	**TOTAL ADMINISTRATIVE COSTS**				
	ENVIRONMENTAL SERVICES (1)				
20	Laundry wages				
21	Housekeeping wages				
22	Maintenance wages				
23	Employer's taxes (Environ.)				
24	Group health, life, and retirement benefits (Environ.)				
25	Worker's comp. insurance (Environ.)				
26	Employment advertising and recruitment (Environ.)				
27	Criminal record checks (Environ.)				
28	Education and training (Environ.)				
29	Supplies, laundry				
30	Supplies, housekeeping				
31	Supplies, maintenance				
32	Utilities				
33	Purchased services, laundry				
34	Purchased services, housekeeping				
35	Purchased services, maintenance				
36	Equipment repairs				
37	Equipment rental (Environ.)				
38					
39	**TOTAL ENVIRONMENTAL SERVICES COSTS**				

Facility	Vendor No.

SCHEDULE C - PART 1 (Cont.)

ALLOCATION OF EXPENSES OF FACILITIES PROVIDING MULTILEVEL CARE

Allocation Basis	ICF	RCF	SNF	ICF/MR	RCF/MR	Total Equal Column 4	Line
							1
							2
							3
							4
							5
							6
							7
							8
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							10
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Facility	Vendor No.
Period of Report: From	To

SCHEDULE C - PART 2

Line	EXPENSES	1 Expenses per General Ledger	2 Adjustment of Expenses Schedule A	3 Adjustment of Expenses Schedule B	4 Resident Expenses
	PATIENT CARE SERVICE COSTS (1)				
	Direct Patient Care Costs				
40	D.O.N wages				
41	R.N. wages				
42	L.P.N. wages				
43	C.N.A. wages				
44	Rehabilitation wages				
45	Activities wages				
46	Social service wages				
47	Employer's taxes (Dir. Health)				
48	Group health, life, and retirement benefits (Dir. Health)				
49	Worker's comp. insurance (Dir. Health)				
50	Employment advertising and recruitment (Dir. Health)				
51	Criminal record checks (Dir. Health)				
52	Education, training (Dir. Health)				
53	Certified nurse aide training				
54	Contracted professional social services				
55	Professional support services				
56	Contracted nursing services				
57	Contracted rehabilitation services				
58					
59	**TOTAL DIRECT PATIENT CARE COSTS**				
	Support Care Costs				
60	Medical record wages				
61	Medical director				
62	Dietary service wages				
63	Employer's taxes (Support)				
64	Group health, life, and retirement benefits (Support)				
65	Worker's comp. insurance (Support)				
66	Employment advertising and recruitment (Support)				
67	Criminal record checks (Support)				
68	Supplies, patient care services				
69	Supplies, dietary services				
70	Supplies, activities				
71	Supplies, social services				
72	Food and nutritional supplements				
73	Pharmacy services				
74	X-Ray services				
75	Laboratory				
76	Professional support services				
77	Equipment rental (Patient Care)				
78					
79	**TOTAL SUPPORT CARE COSTS**				
80	**TOTAL PATIENT CARE SERVICE COSTS**				

Facility	Vendor No.

SCHEDULE C - PART 2 (Cont.)

ALLOCATION OF EXPENSES OF FACILITIES PROVIDING MULTILEVEL CARE

Allocation Basis	ICF	RCF	SNF	ICF/MR	RCF/MR	Total Equal Column 4	Line
							40
							41
							42
							43
							44
							45
							46
							47
							48
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							50
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							79
							80

Facility	Vendor No.
Period of Report: From	To

SCHEDULE C - PART 3

Line	EXPENSES	1 Expenses per General Ledger	2 Adjustment of Expenses Schedule A	3 Adjustment of Expenses Schedule B	4 Resident Expenses
	PROPERTY COSTS (1)				
81	Depreciation **(2)**				
82	Amortization				
83	Real estate taxes				
84	Facility lease				
85	Interest				
86	Property and casualty insurance				
87	Building and grounds repairs				
88					
89	**TOTAL PROPERTY COSTS**				
	OTHER COSTS				
90	Beauty and barber shops				
91	Personal purchases for residents				
92	Income taxes				
93	Officer's life insurance				
94	Director fees				
95	Nonworking officers' salaries				
96	Professional care (Physicians)				
97	Contributions				
98					
99	**TOTAL OTHER COSTS**				
100	**TOTAL OF ALL EXPENSES (3)**				

(1) Costs allocated to certain items are limited. See the instructions for Schedule B for a list and explanation.

(2) Depreciation in Column 1 must agree with total buildings and equipment amount from Schedule D.

(3) Total expenses in Column 1 must be entered on Schedule F, Reconciliation of Equity.

Facility	Vendor No.

SCHEDULE C - PART 3 (Cont.)

ALLOCATION OF EXPENSES OF FACILITIES PROVIDING MULTILEVEL CARE

Allocation Basis	ICF	RCF	SNF	ICF/MR	RCF/MR	Total Equal Column 4	Line
							81
							82
							83
							84
							85
							86
							87
							88
							89
							90
							91
							92
							93
							94
							95
							96
							97
							98
							99
							100

Facility	Vendor No.
Period of Report: From	To

SCHEDULE D

DEPRECIATION AND AMORTIZATION EXPENSE	Asset Cost	Depreciation Allowable in Prior Years	Method	Annual Rate %	Recorded Depreciation Expense	Straight-Line Depreciation
EQUIPMENT:						
Building equipment (fixed)						
Departmental equipment						
Other equipment						
Office furniture and fixtures						
Motor vehicles						
TOTAL						
BUILDINGS: (1)						
CONSTRUCTION						
Facility						
Additions						
Other						
Land improvements						
TOTAL						
TOTAL BUILDINGS AND EQUIPMENT (2)						

(1) The amount of construction in progress.

(2) The amount reported as straight-line depreciation must agree with Schedule C, Line 81. The Asset Cost must agree with Schedule E, Comparative Balance Sheet.

LEASEHOLD IMPROVEMENTS (3)

Description	Construction	Cost	Prior Amount	Period	Recorded	S.T. Line
TOTAL AMORTIZATION						

(3) Questions:

1. Are the lessor or lessee the same person or group of persons or controlled by the same person or group of persons? ❑ Yes ❑ No
2. Does the lease contain an option to purchase the leased property? ❑ Yes ❑ No

Facility	Vendor No.
Period of Report: From	To

SCHEDULE D-1

Has the facility changed owners since July 18, 1984?

❑ Yes. Complete this schedule.

❑ No. This schedule does not apply.

CHANGE OF OWNERSHIP	Previous Owner's Cost	New Purchases Since Change	Depreciation Allowable in Prior Years	Method	Allowable Straight-Line Depreciation
EQUIPMENT:					
Building equipment (fixed)					
Departmental equipment					
Other equipment					
Office equipment					
Motor vehicles					
Less equipment not purchased					
TOTAL					
BUILDINGS:					
Facility					
Additions					
Other					
Land improvements					
Less buildings not purchased					
TOTAL					
TOTAL BUILDINGS AND EQUIPMENT					

Facility	Vendor No.
Period of Report: From	To

SCHEDULE E

COMPARATIVE BALANCE SHEET All information to be taken from the general ledger.	Balance at End of:	
	Current Period	Prior Period
ASSETS:		
Cash		
Investments (Money Market Certificates, Certificates of Deposit, etc.)		
Receivable from residents		
Receivable from others		
Fixed Assets:		
Land		
Buildings and improvements		
Less allowance for depreciation (per books)		
Equipment (including autos)		
Less allowance for depreciation (per books)		
Other assets		
TOTAL ASSETS		
LIABILITIES AND EQUITY:		
Accounts payable		
Accrued taxes (payroll and property)		
Other liabilities		
Notes and mortgages payable to officers, stockholders, owners, etc.		
Notes and mortgages payable to others		
TOTAL LIABILITIES		
EQUITY: **(1)**		
Capital stock		
Paid-in surplus		
Retained earnings		
Partners' and proprietor's capital account(s)		
Partners' and proprietor's drawing account(s)		
Equity (nonprofit organization)		
TOTAL EQUITY		
TOTAL LIABILITIES AND EQUITY		

(1) Total equity must equal the total from Schedule F, Reconciliation of Equity.

Facility	Vendor No.
Period of Report: From	To

SCHEDULE F

RECONCILIATION OF EQUITY	Current Period
TOTAL EQUITY BEGINNING OF PERIOD	
Add:	
Net revenue from Schedule A	
Capital stock issued	
Partners' and proprietor's additional investment	
Other. Explain	
Deduct:	
Expenses per general ledger from Schedule C	
Capital stock retired	
Sub "S" corporation distribution	
Partners' and proprietor's withdrawals	
Dividends	
Other. Explain	
TOTAL EQUITY END OF PERIOD (1)	

(1) Total equity must equal the equity reported on Schedule E, Comparative Balance Sheet.

Facility	Vendor No.
Period of Report: From	To

SCHEDULE G

Do you include as costs, services, facilities or supplies furnished by a related party or organization?

❑ Yes. Complete this schedule.

❑ No. This schedule does not apply.

TRANSACTIONS WITH RELATED ORGANIZATIONS		Included in Report		
Name of Related Party or Organization	Description of Service or Supplies	Amount	Schedule	Line

Facility	Vendor No.
Period of Report: From	To

SCHEDULE H

Nursing facilities participating in the Medicaid program must complete this schedule.

Occupation or Employment Category	**Entry Level Hourly Wage** (1)	**Average Hourly Wage** (2)	**Average Hours Per Patient Day** (3)
Administrative and Business Office Functions			
Laundry Services			
Housekeeping Services			
Maintenance Services			
Registered Nurses			
Licensed Practical Nurses			
Certified Nurse Aides			
Certified Medication Aides			
Restorative Aides			
Activities			
Social Services			
Contracted Nursing Services (4)			
Other Care Services (5)			
Medical Records Services			
Dietary Services			
Other (please list) (6)			

(1) **Entry Level Hourly Wage** For each category listed, calculate the starting hourly wage based upon the most current wages scales established as of the end of the cost reporting period. For categories that include more than one position, average the positions included in the category. The basis for these calculations should remain consistent between periods. If you have changed the basis for these calculations between periods, send a brief explanation for the change with this form.

(2) **Average Hourly Wage** For each category listed, enter the average hourly wage during the cost reporting period. Calculate this amount by dividing the total wages paid by the total hours recorded. For categories that include more than one position, sum all wages for those positions and divide by all hours for those same positions to determine the average hourly wage. The basis for these calculations should remain consistent between periods. If you have changed the basis for these calculations between periods, send a brief explanation for the change with this form.

(3) **Average Hours Per Patient Day** For each category listed, enter this ratio to demonstrate staffing patterns during the cost reporting period. Calculate this amount by dividing the total hours recorded by the patient days in the period. For categories that include more than one position, sum all recorded hours and divide by the patient days. The basis for these calculations should remain consistent between periods. If you have changed the basis for these calculations between periods, send a brief explanation for the change with this form.

(4) **Contracted Nursing Services** Include calculations derived from invoices submitted by outside or temporary staffing agencies. Combine all nursing employment categories covered on these invoices, including RNs, LPNs, CNAs, etc.

(5) **Other Care Services** If you have other categories of employees that don't directly correlate to one of the categories listed, enter them on this line if the position is related to your patient or health care services. Examples include chaplain, religious services, bed-maker, etc.

(6) **Other** If you have any other categories of employees or contracted workers that don't directly correlate to one of the categories listed, complete this line. Note that contracted therapy services or therapy department employees are specifically **excluded** from this report.

2. Certification Page

Complete the certification page as follows:

- **Facility's Name and Address.** Indicate the exact name of the facility (the name as it appears on the state license). BE CONSISTENT! The address line must be completed.
- **Federal Identification Number.** Enter the seven-digit number assigned to the facility by the Department of Human Services. Facilities which offer more than one level of care have more than one vendor number.
- **Type of Control (Item A).** Indicate the ownership or auspices under which the facility is operated. (Check one only.)
- **Accounting Basis (Item B).** Indicate which accounting basis is used by the facility by placing a check mark next to the applicable method. The three methods are described as follows:
  - Accrual: Recording revenues when earned and expense when incurred.
  - Modified Cash: Recording revenue when received and expense when incurred.
  - Cash: Recording revenue when received and expense when paid, after giving effect to adjustments for asset purchases, etc., and depreciation.

  If you do not use the accrual basis of accounting, you must adjust recorded amounts to the accrual basis. This is necessary to obtain information which is comparable among facilities.

  For example, when expenses are incurred in the last month of a reporting period but are paid in the first month of the following report period, include them in the report period in which they are incurred, and not in the report period when paid.

Include expenses which pertain to a whole year (such as dues, property taxes, insurance premiums, professional fees, and similar items) in each six-month report in equal amounts. Take and price physical inventories of supplies and adjust expense accounts at the end of each reporting period.

- **Ownership Information (Item C).** Enter complete and accurate ownership information, including all individuals holding a five percent or greater interest.
- **Number of Public Assistance Recipients (Item D).** Complete Item D to provide the required statistical data. Obtain the census figures on the last day of the month ending the reporting period (per either calendar or fiscal reporting). The report will be returned for completion if Item D is not completed.
- **Statistical Data (Item E).** Compute total bed days (Item E-3) by multiplying licensed capacity by the total number of days in the reporting period.

  Total inpatient days for the period (Item E-4) is the most important statistic in the report. A "patient day" is that period of service rendered a resident between the census-taking hours on two successive days. It is essential that this statistic be accurate and not an estimate of days of care provided.

  Maintain a daily census summary to ensure the needed statistical accuracy. This summary must show the resident count at the beginning of the day, admissions, discharges, and the resident count at the end of the day.

  Include all private-pay and public assistance residents occupying a bed or paying for reserve bed days in the facility during the reporting period. Include the day of discharge only when the resident was admitted that same day.

- **Opinion of Accountant (Item F).** An opinion of a certified public accountant or a public accountant may accompany this report. The Department may require that a facility include the opinion of an accountant as to the fairness of the presentation of reported expense if adjustments made to prior reports indicate disregard of the certification and reporting instructions.

  Always indicate the person to be contacted in the event the agents of the Department have questions concerning the report.

- **Form of Certification and Signatures (Item G).** An authorized officer of the facility must sign the certification. The report must also be signed by the preparer, if other than the authorized officer.

3. Schedule A: Revenues

List revenues as recorded in the general books and records. Revenues are affected to a great extent by the accounting basis and procedures used. Expense recoveries credited to expense accounts should not be reclassified to be reflected as revenues for purposes of this report.

Enter revenues related to services rendered which are not an obligation of the state in Column 2 to the extent of the related expense. These items include beauty and barber shop and personal purchases for residents. Also enter in Column 2 revenues from items and services which are available to residents through other Medicaid vendors.

Apply revenues not related to resident care (Other Revenue Centers) in reduction of the related expense. Enter on Schedule A in Column 2:

- The cost, if known (such as employee meals or telephone expense).
- The gross revenue, if costs cannot be determined.

Investment income adjustment is necessary only if interest expense is incurred, and only to the extent of the interest expense.

Handle income from the sale of craft products as follows:

- When the income is minimal and the raw material is furnished by either the resident or the facility, the income need not be applied as a reduction in expense.
- When the income is substantial and the income is turned over to the facility to offset the cost of raw material, apply the income as an offset of the indicated craft expense.

Apply laundry revenue to laundry expense.

Open lines are provided for entry of sundry sources of revenue not directly related to residents, such as pay telephone commissions, contributions and grants received, etc. These items need not be applied as a reduction of expense.

Report hospice agency revenues on Schedule A under "Other Revenue Centers" as an add-on line item under "Other." Extend this same amount into the second column of Schedule A, as it will be used as an expense offset on Schedule C.

The cross-reference line item for this expense offset on Schedule C should be line 35, 36 or 37. A description of the adjustment would be "Hospice Reimbursement." Record the amount in Column 2 as a Schedule A adjustment.

Report accounts receivable charged off or provision for uncollectable accounts on Schedule A as a deduction from gross revenue. However, if the facility accounts for such revenue deductions as an administrative expense, enter the amounts on Schedule B as "other expense not related to patient care."

The amounts entered on Schedule A, Column 2, are transferred to Schedule C, Column 2. The totals of these columns on both schedules should agree.

For more information on how to apply these instructions to routine services, pharmacy items, medical supplies, ancillary services, and personal needs items, see the explanatory sections that follow.

a. Routine Services

Classify revenue from residents sufficiently in the accounting records to allow preparation of the schedule. It is essential that "routine daily service" represent only the established charge for daily care, excluding additional charges for other services, if any.

Charges for routine services must include all items of services, equipment, and supplies which facilities incur in the provision of routine services. Examples of services and supplies that must be included in routine services are:

- Residents' rooms and furnishings (as required by licensing rules), including maintenance.
- General care and supervision of residents.
- Necessary supervision or assistance with eating, dressing, bathing, grooming, and moving about.
- Laundry services, including washing personal clothing.
- Provision of activities and socialization experience for residents.

For nursing homes, routine services must additionally include:

- All general services, including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinence care, tray service, and enemas.
- Items furnished routinely and relatively uniformly to all residents, such as patient gowns, water pitchers, basins and bed pans.
- Items stocked at nursing stations or on the floor in gross supply and distributed or used individually, such as alcohol, applicators, cotton balls, bandaids, antacids, aspirin and other nonlegend drugs ordinarily kept on hand, suppositories, and tongue depressors.
- Items which are used by individual residents but which are reusable by others and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable medical equipment.

- Special dietary supplements used for tube feeding or oral feeding, such as an elemental high nitrogen diet, even if written as a prescription item by a physician. (These supplements have been classified by the Food and Drug Administration as a food rather than a drug.)

ICF/MRs must also include the following as routine services:

- Training and habilitation services.
- Physical and occupational therapy services.
- Speech pathology and audiology services.
- Recreation services.

b. Pharmacy Items

Approved legend drugs requiring a prescription by law and insulin are paid for directly by Medicaid. Costs of these items must be billed by and paid to a retail pharmacy or a facility having a retail pharmacy license. If the facility pays for these costs and is subsequently reimbursed, these reimbursements must offset the expense.

The following items are also provided to residents by a pharmacy and billed by the pharmacy directly to Medicaid:

- Catheter (indwelling Foley)
- Colostomy and ileostomy appliances
- Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape
- Diabetic supplies (needles and syringe, disposable or reusable, testape, Clinitest tablets and Clinistix)
- Disposable catheterization tray or sets
- Disposable irrigation trays or sets (sterile)
- Disposable saline enemas
- Insulin
- Prescription drugs and devices
- Vitamin pills, prescription (prior approval required)

If the facility pays for these costs and is subsequently reimbursed, those reimbursements must offset the expense.

c. Medical Supplies

With certain exceptions, medical supplies must be provided to Medicaid recipients in NFs and ICF/MRs without additional charge. The cost of these supplies or services must be included in the facility's routine service costs (per diem rate). Examples of these supplies or services include:

- Air mattresses
- Alcohol
- Asepto syringes
- Autoclaves and sterilizers
- Bed linen, towels, washcloths
- Bedpans, urinals
- Bed rails, footboards, cradles
- Bath basin, emesis basin, basin for irrigations
- Charting supplies
- Chux, tripads, toilet paper, sanitary napkins, paper towels, tissues, etc.
- Denture cups, mouthwash cups
- Disinfectant solutions
- Disposable sterile nursing supplies, such as cotton face masks, gloves, tape
- Drinking tubes
- Enema equipment, douche nozzle
- Flashlights
- Fleece pads
- Foot tubs
- Gauze pads, dressings, and bandages
- Hydraulic lifts
- Hypodermic syringes and needles
- Ice bags or equivalent
- Incontinence pads or pants
- Infrared lamps or equivalent
- Irrigating stands
- Intermittent positive pressure breathing equipment
- Intravenous equipment
- Laundry services
- Lubricating jelly and other lubricants
- Moisture-proof draw sheets
- Moisture-proof pillow covers
- Nasogastric feeding equipment
- Occupational therapy
- Oxygen
- Oxygen masks, regulator, humidifiers, hoses, nasal catheters
- Paper handkerchiefs
- Physical therapy
- Rubber goods, such as rectal tubes
- Rubbing compounds, such as alcohol
- Scissors, forceps, and nail files
- Soaking compounds
- Soap containers
- Sphygmomanometers, stethoscopes, and other examination equipment
- Stryker pads

- Subcutaneous equipment
- Suction apparatus and gavage tubing
- Thermometers
- Tongue depressors and applicators
- Tourniquets
- Tracheotomy care equipment
- Weighing scales
- Wheelchairs, walkers, crutches, and canes

Some medical supplies or services which are charged to the resident are accounted for on Schedule C as "items purchased for resale" and must be posted to Schedule A on the appropriate line. This is not necessary if these supplies or services are provided free of charge to Medicaid residents and the charges are for private-pay residents only.

Examples of these supplies include vitamins which are not prescribed, liniment, and certain other items which contribute to the comfort of the recipient, but have no therapeutic value.

d. Ancillary Services

When the facility charges private-pay residents for pharmacy, medical supplies, occupational and recreational therapy, therapy supplies, and related services, such as reality therapy, rehabilitation programs, and temporary private duty nursing, revenue from these sources must be applied in reduction of the related expense.

The resulting expense, after adjustment, should not be a negative figure. A revenue classification "miscellaneous" or "sundry" ordinarily requires an analysis and determination of the amounts included which represent expense recoveries or income to be applied in reduction of a related expense.

The following items and services are available to residents through other Medicaid programs, and are billed by the supplying vendor. If the facility pays for these costs and is subsequently reimbursed, those reimbursements must offset the expense.

- Ambulance service
- Audiologist services
- Braces and prosthetic devices
- Chiropractor services
- Dental work and equipment
- Hearing aid batteries and cords
- Hearing aid repairs
- Hearing aids
- Hospital services
- Modifications to orthopedic shoes
- Optician and optometrist services
- Occupational or physical therapy provided in a doctor's office or hospital outpatient clinic
- Physician services
- Podiatrist services
- Repair of medical equipment and appliances
- Skilled services
- X-rays, laboratory work

e. Personal Needs Items

Residents may choose to purchase personal needs items through the facility. Revenues from these items must offset the related expense account.

Licensing rules for facilities require that the facility provide materials for activity programs and recreation. Items purchased for general use by the facility should be included in routine service costs and should not be charged to residents.

A resident may purchase a wheelchair from personal needs funds to be used exclusively by the resident. A wheelchair purchased by a resident reverts to the resident's estate or to relatives upon death.

A resident may purchase a television set or an air conditioner from personal needs funds for use in the resident's room only. Appliances must revert to the resident's estate or to relatives. Reasonable charges for electricity for use of appliances are allowable personal needs fund charges, if a like amount is included in Schedule C as a reduction in cost for utilities (Line 31).

In NFs and ICF/MRs, if nonlegend drugs or nonprescription vitamin pills are ordered by a physician, they must be included in routine service charges and are an allowable cost. If a resident requests these items and the items are not ordered by a physician, they may be charged to the resident.

f. Average-Private Pay Rate

To compute the average private pay rate, accumulate the total monthly changes for all private-pay residents for the six-month period. Divide this sum by the total patient days for all private-pay residents for the same period.

"Total monthly changes" include the basic change plus all changes for extra care, services, or supplies.

4. Schedule B: Expense Adjustments

Certain expenses must be eliminated or limited because they are not normally incurred in providing patient care. Rules concerning these expenses are set forth below. The amounts entered on Schedule B are transferred to Schedule C, Column 3. The totals of these columns on both schedules must agree.

The following expenses are not reimbursable:

- **Income Taxes.** Federal and state income taxes are not allowable as reimbursable costs.
- **Fees Paid Directors and Nonworking Officers' Salaries.** Fees paid to directors and nonworking officers' salaries are not allowable as reimbursable costs.

- **Bad Debts.** Bad debts are amounts considered to be uncollectable from accounts and notes receivable which were created or acquired in providing services. Bad debts are not an allowable cost.
- **Charity Allowances.** Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the resident. Charity allowances are not an allowable cost.

- **Courtesy Allowances.** Courtesy allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the resident. Courtesy allowances are not an allowable cost.
- **Entertainment.** Entertainment for which the resident is required to pay is not included as an allowable cost. Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense. Examples are as follows:
  - Birthday parties.
  - Outside entertainers, exclusive of volunteer groups (religious, high school, community groups, etc.).
  - Activity director salary, unless working as a volunteer.
  - Expenses incurred in the activities program are an allowable expense. (See also the instructions for Personal Needs Items under Schedule A.)
  - Concerts, athletic events, shows and other entertainment which require an outlay of funds by the facility are allowable expenses.
- **Loan Acquisition Fees and Standby Fees.** Loan acquisition fees and standby fees are not considered part of the current expense of resident care, but should be amortized over the life of the related loan.
- **Capital Expenditures.** Providers constructing new facilities or expanding existing facilities must receive certificate of need approval from the Iowa Department of Public Health. When prior approval is not obtained, depreciation, interest on borrowed funds and other costs attributable to such capital expenditures are not allowed as reimbursable expenses.
- **Legal Fees.** Reasonable legal fees are an allowable cost when directly related to patient care. Legal fees related to defense against threatened state license revocation or Medicaid decertification are allowable costs only up to the date a final appeal decision is issued. However, in no case will legal fees related to Medicaid decertification be allowable costs for more than 120 days following the decertification date.

The following sections give more detailed information on the limits for:

- Travel expenses.
- Compensation of owners and related parties.
- Items furnished by related organizations.
- Rental costs.
- Depreciation.
- Interest.

a. Travel

Personal travel and entertainment expenses are not allowable as reimbursable costs. Prorate expenses such as rental or depreciation of a vehicle and travel expenses which include both business and personal expense.

Maintain records to substantiate the indicated charges. Amounts that appear excessive may be limited after considering the specific circumstances. Guidelines relating to this area are as follows:

- No commuter travel (from private residence to facility and return) is allowed as an audit cost in computing the facility's per diem rate. This includes owners, owner-administrators, administrators, assistant administrators, nursing directors, and all other employees of the facility.
- The expense of one car, one van, or both, designated for use in transporting residents is an allowable cost. (This restriction on number of vehicles does not apply to ICF/MRs.) Travel related to resident care is allowable. Document all expenses by a sales slip, invoice, or other document describing the expense and identifying the vehicle.
- Travel for which the resident is required to pay must not be included as a travel expense. If the expense cannot be identified and eliminated from other travel expense, revenue from this source must be included on Schedule A and must offset expense on Schedule C.

- Expenses associated with association business meetings are allowable if limited to individual members of associations which are members of a national affiliate.
- Expenses associated with workshops, symposiums, and meetings which provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing are also allowable expenses.
- Travel of an emergency nature required for the purchase of supplies or for repairs for machinery, building or equipment is an allowable travel expense.
- Allowable expenses for resident transport, business meetings, continuing education and emergencies (as described above) are limited to six percent of total administrative expense. This restriction does not apply to ICF/MRs.

At the annual contract review, each facility must verify that it either:

- Has a transportation plan approved by the Iowa Department of Transportation (DOT),
- Has notification that it is exempt, is awaiting response from the DOT, or
- Has been notified that its plan is in noncompliance with requirements of the DOT.

If the facility has a noncompliant plan, the transportation cost of the facility is not allowed in computing the allowable per diem rate of the facility. Statements indicating exemption or compliance are subject to follow-up audit review by the Department. If supportive documentation cannot be produced, then transportation cost will be disallowed.

b. Compensation of Owners or Related Parties

Owners of provider organizations often render services as managers, administrators, or in other capacities. In such cases, it is equitable that reasonable compensation for the services rendered be an allowable cost. To do otherwise would disadvantage these owners in comparison with providers employing persons to perform a similar service.

Ordinarily, compensation paid to proprietors is a distribution of profits. However, where a proprietor renders necessary services for the facility, the facility is in effect employing the proprietor's services. A reasonable compensation for these services is an allowable cost.

For corporate providers, the salaries of owners who are employees are subject to the same requirements of reasonableness of compensation may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable facilities, or it may be determined by other appropriate means.

A reasonable allowance of compensation for services of owners or related parties is an allowable cost, provided the services are actually performed in a necessary function. Maintain adequate time records to justify reported expenses. Adjustments may be necessary to provide compensation as an expense for non-salaried working proprietors and partners.

The following persons are considered **related parties**:

- Husband and wife;
- Natural parent, child and sibling;
- Adopted child and adoptive parent;
- Grandparent and grandchild;
- Stepparent, stepchild, stepbrother, and stepsister;
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law.

Compensation means the total benefit received by the owner or related party for the services the proprietor renders to the facility. It includes:

- Salaries paid for managerial, administrative, professional and other services.
- Amounts paid by the facility for personal benefits of the proprietor, e.g., health insurance, food or meals, personal utilities, taxes, yard care, etc.
- The cost of assets and services which the proprietor receives from the facility e.g., life insurance, key man insurance, personal care, etc.
- Deferred compensation.

Members of religious orders serving under an agreement with their administrative office are allowed salaries equal to those paid to persons performing comparable services. If the facility provides maintenance to such persons (room, board, clothing, etc.), deduct the value of these benefits from the amount otherwise allowed for a person not receiving maintenance.

Necessary means that the function:

- Is such that if the owner or related party had not rendered the service, the facility would have to employ another person to perform the service.
- Is pertinent to the operation and sound conduct of the facility.

Reasonable means that the compensation allowance:

- Is an amount that would ordinarily be paid for comparable services by comparable facilities.
- Depends upon the facts and circumstances of each case.

Federal financial participation is available for owner's compensation, provided the schedules of payment established by the Department do not exceed the combined payments received by providers from the intermediaries and beneficiaries under Medicare for furnishing comparable services under comparable circumstances.

Guidelines for determining reasonableness have been established based upon a review of compensation of owners and nonowners with the assistance of the regional Health and Human Services office. These guidelines are as follows:

- **Administrator:** A monthly base maximum compensation is allowed for an administrator, plus a given amount for each licensed bed over 60, not to exceed a set limit per month. An administrator is considered to be involved in ownership of a facility when the administrator holds an interest of five percent or more.
- **Assistant administrator:** A maximum monthly compensation is allowed for an assistant administrator for a home having a licensed capacity of 151 or more beds.
- **Nursing director:** The maximum allowed compensation for a director of nursing is 60 percent of the amount allowed for the administrator, or a set amount per month, whichever is greater.
- **Other employees:** Compensation amounts for other employees must be reasonable and necessary.

Contact the Division of Medical Services for current limits. A notice is issued to all facilities when these limits change.

Management fees are computed on the same basis as the owner-administrator's salary, but the amount paid the resident administrator is deducted. If the parent company can separately identify accounting costs, these costs are allowed.

Expenses related to patient care which are incurred by a central office on behalf of the facility are allowable to the extent that the cost would be allowed if paid directly by the facility.

c. Items Furnished by Related Organizations

Costs of supplies furnished by a related party or organization are reimbursable if included in the costs to the related party or organization. However, such costs must not exceed the price of comparable supplies that could be purchased elsewhere. Complete Schedule G, Transactions With Related Organizations, to indicate all items purchased from related parties.

Related to the facility means that the facility, to a significant extent, is associated or affiliated with, or has control of, or is controlled by the organization furnishing the services, facilities, or supplies.

Common ownership means that a person or persons possess significant ownership or equity in the facility and the institution or organization serving the provider.

Control means that a person or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

Where the facility obtains items of service, facilities, or supplies, from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owners of the provider, in effect the items are obtained from itself.

One example is a corporation building a facility and then leasing it to another corporation controlled by the owner. Reimbursable cost should not exceed the costs for these items to the supplying organization.

However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the facility will not exceed the market price.

An exception is provided to this general principle if the facility demonstrates by convincing evidence:

- That the supplying organization is a bona fide separate organization.
- That a substantial part of its business activity of the type carried on with the facility is transacted with others than the facility.
- That there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization.
- That the services, facilities, or supplies are those which commonly are obtained by institutions such as the facility from other organizations and are not a basic element of patient care originally furnished directly to patients by such institutions.
- That the charge to the facility is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

In such cases, the charges by the supplier for the services, facilities, or supplies must be allowable costs.

d. Rental Costs

When an operator of a participating facility enters into an agreement to rent the facility from the former owner or operator, rental expense must be determined by identifiable property costs and by relationship of the provider to the landlord.

When the provider rents from a nonrelated party, the amount of rental expense must be based on the identified cost of the facility, plus the landlord's other expenses, and a reasonable rate of return, not to exceed actual rent payments.

When the provider rents from a related party, the amount of rental expense must be no more than the amortized cost of the facility plus the landlord's other expenses.

e. Depreciation

Depreciation based upon tax cost may be included as a resident cost using only the straight-line method of computation and recognizing the estimated useful life of the asset. When accelerated methods of computation have been elected for income tax purposes, an adjustment must be made.

With any change of ownership of a nursing facility or ICF/MR, including lease arrangement, no increase in the value of the property is allowed in determining the Medicaid rate for the new owner. (Facilities having a change in ownership complete Schedule D-1 for each reporting period.)

For RCFs, the new owner or operator must either:

- Continue with previous owner's depreciation schedule, or
- Set up a new depreciation schedule using the amount obtained by deducting the depreciation expenses incurred since July 1, 1980, from the value of depreciable real property. The value will be the sale price or appraised value, whichever is less. (441 IAC 54.3(12)"c")

f. Interest

Necessary and proper interest on both current and capital indebtedness is an allowable cost.

Interest means the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expenses.

Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment and capital investments. Generally, loans for capital purposes are long-term loans.

Necessary means that the interest:

- Is incurred on a loan made to satisfy a financial need of the provider. Loans which result in excess funds or which provide investments are not considered necessary.
- Is incurred on a loan made for a purpose reasonably related to patient care. Loans made for the purpose of acquiring capital stock and treasury stock are not considered reasonably related to patient care.
- Is reduced by investment income, except where such income is from restricted or unrestricted gifts and grants, which are held separate and not mingled with other funds. Income from funded depreciation or a provider's qualified pension fund is not used to reduce interest expense.

Proper means that interest:

- Is incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing when the loan was made.
- Is paid to a lender not related through control or ownership or personal relationship to the borrowing organization.

To be allowable, interest expense generally must be incurred on indebtedness established with a lender or lending organization not related through control, ownership, or personal relationship to the borrower.

Presence of any of these factors affects the "bargaining" process that usually accompanies the making of a loan, and could suggest an agreement on higher rates of interest or of unnecessary loans.

However, under some circumstances interest on loans to providers by lenders or lending organizations related through control, ownership, or personal relationship to the borrower is allowable as a cost at a rate not in excess of the current interest rate at the time the loan was made. The **current interest rate** is intended to mean **what an investor could receive on funds invested in the locality**.

Loans must be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. The intent of this provision is to ensure that loans are legitimate and needed, and that the interest rate is reasonable.

Where the general fund of a provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost.

The same treatment is accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the provider or from the provider's qualified pension fund. If a provider operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost.

Where funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years from earnings on funded depreciation.

A similar treatment is accorded deposits in the provider's qualified pension fund when such deposits are used for other than the purpose for which the fund was established.

g. Change of Facility Ownership

The person responsible for transfer of ownership or for termination is responsible for submission of a final *Financial and Statistical Report* through the date of the transfer. No payment to the new owner will be made until formal notice of the change is received.

The following situations are defined as transfer of ownership:

- When a facility is owned by a **partnership**, the removal, addition, or substitution of a partner, in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement. A transfer of ownership has occurred.
- When a facility is a **sole proprietorship**, a transfer of title and property to another party constitutes a change of ownership.
- When the facility is a **corporation**, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.
- When a participating facility is **leased**, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

With any change of ownership of an NF or ICF/MR (including lease agreements), no increase in the value of the property will be allowed in determining the Medicaid rate for the new owner. When filing the first cost report, the new owner must either:

- Continue the schedule of depreciation and interest established by the previous owner, OR
- Choose to claim interest expense using amortization of the actual rate of interest.

The results of the interest expense calculation must not be higher than would be allowed under Medicare principles of reimbursement. Interest must be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

Other acquisition costs of the new owner will not be allowed. These include legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property.

In general, follow the provisions of Section 1861 (v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership, except that there is no provision for return on equity or recapture of depreciation.

A new owner or lessee wishing to claim a new rate of interest must submit documentation which verifies:

- The amount of down payment made,
- The actual rate of interest, and
- The number of years required for repayment with the next cost report.

In the absence of the necessary supportive documentation, interest and other property costs for all facilities which have changed or will change ownership must continue at the rate allowed the previous owner.

5. Schedule C: Expenses

Expenses reported on Schedule C are divided into the following sections and subsections:

- Administrative costs
- Environmental services
- Patient care service costs
  - Direct patient care costs
  - Support care costs
- Property costs
- Other costs

The accounts under these categories are segregated to provide required statistical information. All expense carried on the provider's general ledger must be entered in Column 1.

Column 2 and 3 (Adjustment of Expenses) reflect adjustments from Schedule A and B for items which are not allowable as costs to provide resident care. Column 4 shows the expense related to resident care.

Costs allocated to certain line items on Schedule C are limited. See **Schedule B: Expense Adjustments** for an explanation of these limits.

Following is a description of each line of Schedule C.

a. Administrative Costs

LINE 1: ADMINISTRATOR WAGES. Salary of the facility administrator including regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation paid to the administrator through payroll. See Schedule B instructions for limits that may apply.

LINE 2: BUSINESS OFFICE WAGES. Salaries and wages for other administrative positions, such as assistant administrator, bookkeeper, and clerical support. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation paid to administrative staff through payroll.

LINE 3: EMPLOYERS TAXES (ADMINISTRATIVE). Payroll taxes related to the salaries and wages included in lines 1 and 2.

LINE 4: GROUP HEALTH, LIFE, AND RETIREMENT BENEFITS (ADMINISTRATIVE). Health, life and retirement benefits related to the salaries and wages in lines 1 and 2. (Report officer's life insurance on line 93.)

LINE 5: WORKER'S COMP INSURANCE (ADMINISTRATIVE). Worker's compensation insurance expenses related to the salaries and wages in lines 1 and 2.

LINE 6: EMPLOYMENT ADVERTISING AND RECRUITMENT (ADMINISTRATIVE). Costs of advertising for hiring of administrative positions.

LINE 7: CRIMINAL RECORD CHECKS (ADMINISTRATIVE). Costs associated with conducting criminal record checks for positions included in lines 1 and 2.

LINE 8: EDUCATION AND TRAINING (ADMINISTRATIVE). Costs of training seminars and courses, such as registration fees, course materials, and associated travel and lodging costs.

LINE 9: SUPPLIES (ADMINISTRATIVE). Expenses for administrative operations such as computer, postage, copier, and printing supplies.

LINE 10: TELEPHONE. Expenses for telephone and paging services.

LINE 11: EQUIPMENT RENTAL (ADMINISTRATIVE). Rent expense of equipment used to support administrative operations.

LINE 12: HOME OFFICE COSTS. Costs for essential services provided from a central location.

Facilities with a home office or principal headquarters which receive essential services from this office must annually provide a copy of their general ledger trial balance. These facilities must also provide a copy of their grouping schedules which demonstrate how the accounts on their trial balance are grouped by the individual line items on their cost reports.

These schedules must demonstrate the basis for allocation of home office costs to the specific line items on each facility cost report, including compliance and limitations on:

- Owner and related party compensation
- Purchase of services from related parties
- Allocation methods to Iowa nursing facilities and other businesses
- Travel and transportation costs
- Advertising
- Director's fees and related expenses
- Contributions
- Income tax

LINE 13: MANAGEMENT FEES. Costs for management fees of a facility.

LINE 14: ACCOUNTING COSTS, LEGAL, AND OTHER PROFESSIONAL FEES. Costs for contracted accounting, legal, or other administrative professional services.

LINE 15: GENERAL LIABILITY INSURANCE. Expense of general liability insurance.

LINE 16: TRAVEL, ENTERTAINMENT, AND AUTO. Costs for entertainment, travel other than related to education above, and expenses for agency-owned vehicles when not providing transportation for patients. These expenses are limited to 6% of line 18 minus this line. See Schedule B instructions for other limits that may apply.

LINE 17: ADVERTISING AND PUBLIC RELATIONS. Costs for general advertising of services, marketing, development, promotion, and public relations. This line is limited to $3,600.

LINE 18: BLANK. Use this line for any miscellaneous administrative costs that do not fit the definitions of the lines above. If more than one type of cost is included in this line, please provide a schedule detailing the costs involved.

LINE 19: TOTAL ADMINISTRATIVE COSTS. Represents the total of all costs reported in lines 1 through 18.

b. Environmental Services Costs

LINE 20: LAUNDRY WAGES. Salaries and wages for positions that provide laundry services. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation paid to laundry staff through payroll.

LINE 21: HOUSEKEEPING WAGES. Salaries and wages for positions that provide housekeeping services. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation paid to housekeeping staff through payroll.

LINE 22: MAINTENANCE WAGES. Salaries and wages for positions that provide maintenance services. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation paid to maintenance staff through payroll.

LINE 23: EMPLOYERS TAXES (ENVIRONMENTAL). Payroll taxes related to the salaries and wages in lines 20, 21, and 22.

LINE 24: GROUP HEALTH, LIFE, AND RETIREMENT BENEFITS (ENVIRONMENTAL). Health, life and retirement benefits related to the salaries and wages in lines 20, 21, and 22.

LINE 25: WORKER'S COMP INSURANCE (ENVIRONMENTAL). Worker's compensation insurance expenses related to the salaries and wages in lines 20, 21, and 22.

LINE 26: EMPLOYMENT ADVERTISING AND RECRUITMENT (ENVIRONMENTAL). Costs of advertising for hiring of environmental service positions.

LINE 27: CRIMINAL RECORD CHECKS (ENVIRONMENTAL). Costs associated with conducting criminal record checks for positions included in lines 20, 21, and 22.

LINE 28: EDUCATION AND TRAINING (ENVIRONMENTAL). Costs of training seminars and courses, including registration fees, course materials, and associated travel and lodging costs.

LINE 29: SUPPLIES, LAUNDRY. Expenses for supplies used to provide laundry services.

LINE 30: SUPPLIES, HOUSEKEEPING. Expenses for supplies used to provide housekeeping services.

LINE 31: SUPPLIES, MAINTENANCE. Expenses for supplies used to provide maintenance services.

LINE 32: UTILITIES. Electricity, gas, water, sewer, and other utility expenses.

LINE 33: PURCHASED SERVICE, LAUNDRY. Cost of outside contractors to provide laundry services.

LINE 34: PURCHASED SERVICES, HOUSEKEEPING. Cost of outside contractors to provide housekeeping services.

LINE 35: PURCHASED SERVICES, MAINTENANCE. Cost of outside contractors to provide maintenance services.

LINE 36: EQUIPMENT REPAIRS. Expenses related to equipment service agreements and to repairing facility equipment.

LINE 37: EQUIPMENT RENTAL (ENVIRONMENTAL). Rental expense of equipment used to support environmental services, such as floor scrubbers.

LINE 38: BLANK. Use this line for miscellaneous environmental services costs that do not fit the definitions of the lines above. If more than one type of cost is included in this line, please provide a schedule detailing the costs included.

LINE 39: TOTAL ENVIRONMENTAL SERVICES COSTS. The total of all costs in lines 20 through 38.

c. Direct Patient Care Costs

LINE 40: D.O.N. WAGES. Salaries and wages for the director of nursing and assistant director of nursing. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation paid to the director of nursing and assistant director of nursing through payroll.

LINE 41: R.N. WAGES. Salaries and wages for registered nurses. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation paid to registered nurses through payroll.

LINE 42: L.P.N. WAGES. Salaries and wages for licensed professional nurses. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation paid to LPNs through payroll.

LINE 43: C.N.A. WAGES. Salaries and wages for certified nurse aides and certified medication aides. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation paid to CNAs through payroll.

LINE 44: REHABILITATION WAGES. Salaries and wages for physical therapists, recreational therapists, occupational therapists, respiratory therapists, speech therapists, and certified rehabilitation nurse aides.

Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation paid to therapists through payroll. Reduce any expenses for providing services to private pay residents by the related revenue.

LINE 45: ACTIVITIES WAGES. Salaries and wages for positions providing activity services. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation paid to activities staff through payroll.

LINE 46: SOCIAL SERVICE WAGES. Salaries and wages for positions providing social services. Report costs associated with a chaplain on this line. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation paid to social service staff through payroll.

LINE 47: EMPLOYERS TAXES (DIRECT HEALTH). Payroll taxes related to the salaries and wages included in lines 40 through 46.

LINE 48: GROUP HEALTH, LIFE, AND RETIREMENT BENEFITS (DIRECT HEALTH). Health, life and retirement benefits related to the salaries and wages in lines 40 through 46.

LINE 49: WORKER'S COMP INSURANCE (DIRECT HEALTH). Worker's compensation and professional liability insurance expense related to the salaries and wages in lines 40 through 46.

LINE 50: EMPLOYMENT ADVERTISING AND RECRUITMENT (DIRECT HEALTH). Advertising for hiring of patient care service positions in lines 40 through 46. Hiring bonuses are reported on this line.

LINE 51: CRIMINAL RECORD CHECKS (DIRECT HEALTH). Costs associated with conducting a criminal record check for positions included in lines 40 through 46.

LINE 52: EDUCATION, TRAINING (DIRECT HEALTH). Costs of training seminars and courses, registration fees, course materials, and associated travel and lodging costs for patient care services training except certified nurse aide training relating to certification.

LINE 53: CERTIFIED NURSE AIDE TRAINING. Costs of training courses for certification of nurse aides. Do not include other types of training costs in this line. The federal government reimburses costs associated with CNA training at a different rate than other facility costs. Although this does not affect an individual facility's reimbursement rate, it does affect the federal funding for the Iowa Medicaid program.

LINE 54: CONTRACTED PROFESSIONAL SOCIAL SERVICES. Costs for outside contractors to provide social services.

LINE 55: PROFESSIONAL SUPPORT SERVICES. Costs for professional support services, such as those of a quality assurance nurse.

LINE 56: CONTRACTED NURSING SERVICES. Costs for outside contractors to provide nursing services.

LINE 57: CONTRACTED REHABILITATION SERVICES. Costs for outside contractors to provide rehabilitative therapy services.

LINE 58: BLANK. Use this line for miscellaneous patient care service costs that do not fit the definitions of the lines above. If more than one type of cost is included in this line, please provide a schedule detailing the costs involved.

LINE 59: TOTAL DIRECT PATIENT CARE. The total costs from lines 40 through 58.

d. Support Care Costs

LINE 60: MEDICAL RECORD WAGES. Salaries and wages for positions responsible for maintaining medical records. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation paid to medical records staff through payroll.

LINE 61: MEDICAL DIRECTOR. Expenses associated with medical director services.

LINE 62: DIETARY SERVICE WAGES. Salaries and wages for positions that provide dietary services such as dietary supervisors, dietary aides, cooks, and dishwashers. Include in this line all regular pay, overtime pay, sick pay, holiday pay, vacation pay, bonus, and other compensation paid to dietary staff through payroll.

LINE 63: EMPLOYERS TAXES (SUPPORT). Payroll taxes related to the salaries and wages included in lines 60 through 62.

LINE 64: GROUP HEALTH, LIFE, AND RETIREMENT BENEFITS (SUPPORT). Health, life and retirement benefits related to the salaries and wages in lines 60 through 62.

LINE 65: WORKER'S COMP INSURANCE (SUPPORT). Worker's compensation insurance expense related to the salaries and wages in lines 60 through 62.

LINE 66: EMPLOYMENT ADVERTISING AND RECRUITMENT (SUPPORT). Costs of advertising for hiring of support care positions in lines 60 through 62.

LINE 67: CRIMINAL RECORD CHECKS (SUPPORT). Costs associated with conducting a criminal record check for positions included in lines 60 through 62.

LINE 68: SUPPLIES, PATIENT CARE SERVICES. Costs of supplies necessary to provide patient care services, such as medical supplies. Any expenses for providing services to private pay residents should be reduced by the related revenue.

LINE 69: SUPPLIES, DIETARY SERVICES. Costs of non-food supplies necessary to provide dietary services.

LINE 70: SUPPLIES, ACTIVITIES. Costs of supplies used as part of the facility's activities program.

LINE 71: SUPPLIES, SOCIAL SERVICES. Costs of supplies used to deliver social services in the facility.

LINE 72: FOOD AND NUTRITIONAL SUPPLEMENTS. Food and nutritional supplement costs.

LINE 73: PHARMACY SERVICES. Costs of drugs and pharmaceuticals. Reduce any expenses for providing services to private pay residents by the related revenue.

LINE 74: X-RAY SERVICES. X-ray expenses.

LINE 75: LABORATORY. Laboratory services expenses.

LINE 76: PROFESSIONAL SUPPORT SERVICES. Costs for outside contractors to provide professional support services. Report contracted dietary consultant fees here.

LINE 77: EQUIPMENT RENTAL (PATIENT CARE). Rental expense of equipment used to support the patient care services area, such as beds, special chairs, and lifts.

LINE 78: BLANK. Use this line for any other miscellaneous support services costs that does not fit the definitions of the lines above. If more than one type of cost is included in this line, please provide a schedule detailing the costs involved.

LINE 79: TOTAL SUPPORT CARE COSTS. Total costs from lines 60 through 78.

LINE 80: TOTAL PATIENT CARE SERVICES. The sum of lines 59 and 79.

e. Property Costs

LINE 81: DEPRECIATION. Facility depreciation for equipment and buildings. Adjust these costs on Schedule B to convert book depreciation, if other than straight-line, to the straight-line method of depreciation.

The amounts on this line should be consistent with the total amount reported on Schedule D or D-1. See Schedule B instructions for limits that may apply.

LINE 82: AMORTIZATION. Amortization costs for the facility on leasehold improvements, start up costs, etc.

LINE 83: REAL ESTATE TAXES. Property taxes incurred for the facility.

LINE 84: FACILITY LEASE. Rent expenses for lease of the facility only. Include expenses related to rental of facility equipment on the equipment rental lines of the other sections. Facility rent is limited. See instructions under Schedule B for an explanation of the limits.

LINE 85: INTEREST. Necessary and proper interest incurred on facility loans. Interest paid to a related party is not an allowable expense. Interest expense should be reduced by investment income. See Schedule B instructions for limits that may apply.

LINE 86: PROPERTY AND CASUALTY INSURANCE. Property and casualty insurance on the facility buildings and equipment.

LINE 87: BUILDING AND GROUNDS REPAIRS. Costs for repairing the facility's building and grounds.

LINE 88: BLANK. Use this line for any other miscellaneous property costs that do not fit the definitions of the lines above. If more than one type of cost is included in this line, please provide a schedule detailing the costs involved.

LINE 89: TOTAL PROPERTY COSTS. Total costs from lines 81 through 88.

f. Other Costs

LINE 90: BEAUTY AND BARBER SHOP. Costs to provide beauty and barber shop services at the facility. These costs are not reimbursable, and should be offset 100%.

LINE 91: PERSONAL PURCHASES FOR RESIDENTS. Costs of providing personal items for patients at the facility. These costs are not reimbursable, and should be offset 100%.

LINE 92: INCOME TAXES. Income tax expense incurred during the period. These costs are not reimbursable, and should be offset 100%.

LINE 93: OFFICER'S LIFE INSURANCE. Costs to maintain a key man insurance policy on an officer or administrator where the facility is the beneficiary. These costs are not reimbursable, and should be offset 100%.

LINE 94: DIRECTOR'S FEES. Fees incurred for the board of directors. These costs are not reimbursable, and should be offset 100%.

LINE 95: NON-WORKING OFFICER'S SALARIES. Salaries and wages paid to officers who did not work at the facility. These costs are not reimbursable, and should be offset 100%.

LINE 96: PROFESSIONAL CARE - PHYSICIANS. Payments made to physicians for other than medical director services. These costs are not reimbursable, and should be offset 100%.

LINE 97: CONTRIBUTIONS. Donations and contributions made by the facility. These costs are not reimbursable, and should be offset 100%.

LINE 98: BLANK. Use this line for any other miscellaneous costs that do not fit the definitions of the lines above.

LINE 99: TOTAL OTHER COSTS. The total costs from lines 90 through 98.

LINE 100: TOTAL OF ALL EXPENSES. The total costs from lines 19, 39, 80, 89, and 99.

6. Schedules D, D-1, E, F, G, and H

Take the information needed to complete Schedules D, D-1, E, F, G, and H from the depreciation schedule and general ledger of the provider. Each schedule is generally self-explanatory. The information must be completed accurately and totals transferred to other schedules as appropriate.

Schedule H must be completed by nursing facilities participating in the Medicaid program.

X. AUDITS, SANCTIONS, AND APPEALS

The following sections cover:

- Audit of the *Financial and Statistical Report* and potential penalties.
- Audit of billings and handling of residents' funds and potential penalties.
- Interest charges for a credit balance owed to the Department.
- Sanctions for failure to meet participation requirements.
- Fines for notification of the time or date of a certification survey.
- Fines for falsification of a resident assessment.
- Circumstances requiring independent assessors for resident assessments.
- Appeal procedures.

A. Audit of *Financial and Statistical Report*

Upon proper identification, authorized state or federal representatives have the right to audit the general financial records of a facility, using generally accepted auditing procedures. This audit determines if expenses reported on the *Financial and Statistical Report*, form 470-0030, are reasonable and proper according to Medicaid rules. The audits may be done in an on-site visit either:

- To the facility,
- To the facility's central accounting office, or
- To offices of the facility's agents.

When a proper per diem rate cannot be determined through generally accepted and customary auditing procedures, the auditor will examine and adjust the report to arrive at what appears to be an acceptable rate. The auditor then recommends to the Department of Human Services that the indicated per diem should be reduced to 75% of the established payment rate for the ensuing six-month period.

If the situation is not remedied on the subsequent form 470-0030, the facility will be suspended and eventually canceled from the Medicaid program.

When a facility continues to include as an item of cost an item which was removed in a prior audit by an adjustment in the total audited costs, the auditor may recommend to the Department that the per diem be reduced to 75 percent of the current payment rate for the following six-month period. After considering the seriousness of the exception, the Department may make this reduction. Facilities will be informed in writing of Department actions.

B. Audit of Billing and Handling Resident Funds

Upon proper identification, field auditors of the state of Iowa or representatives of the Department of Health and Human Services have the right to audit:

- Billings to the Department of Human Services and receipts of financial participation to ensure that:
  - The facility is not receiving payment in excess of the contractual agreement.
  - All other aspects of the contractual agreement are being followed.
- Records of the facility to determine proper handling of personal needs funds.

On the auditor's recommendation, the Department will request repayment of sums inappropriately billed to the Department or collected from the resident. The facility must make repayment either to the Department or to the resident involved.

The facility has 60 days to review the audit and repay the requested funds or present supporting documentation which show that the requested refund amount, or part of it, is not justified.

When the facility fails to comply, the requested refunds may be withheld from future payments to the facility. The withholding will not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding will continue until the entire refund is recovered.

If the audit results indicate significant problems, a facility may be referred to the attorney general's office for whatever action is appropriate.

When the fiscal records (including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices and audit reports, as compiled by or for the facility) are not adequately maintained to render a proper per diem rate, the auditor will:

- Examine and adjust the report to arrive at what appears to be an acceptable rate.
- Recommend to the Department that the indicated per diem be reduced by 25% for the next reporting period.

If the situation is not remedied on the next *Financial and Statistical Report*, the facility will be suspended and eventually canceled from participation in the program.

When the facility continues to include an item of expense which had been removed from an earlier report, the auditor will recommend that the Department reduce the audited per diem by 25% for the next reporting period.

When exceptions are taken during an audit which are similar to the exceptions taken in a prior audit, the Department may reduce payment to the facility to 75 percent of the current payment rate, after considering the seriousness of the exceptions.

If a facility has a credit balance due the Department for more than 60 days, interest will be also due to the Department.

C. Interest Charge for Credit Balance

When a facility has a total Medicaid credit balance of more than $500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance, the Department will charge interest at 10 percent per year on each overpayment. The interest begins to accrue retroactively to the first full month that the provider had a credit balance over $500.

Agreement to repay must be made with the Division of Medical Services, Bureau of Health Care Purchasing and Quality Management, or the Division of Data Management, Quality Assurance Section.

D. Fine for Notification of Time or Date of Survey

Any person who notifies a nursing facility or causes a nursing facility to be notified of the time or date on which a survey is scheduled to be conducted, is subject to a fine not to exceed $2,000.

E. Fine for Falsification of a Resident Assessment

A person who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each falsified assessment.

A person who willfully and knowingly causes another person to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each falsified assessment. These fines are administratively assessed by the Department of Inspections and Appeals (DIA).

In determining the monetary amount of the penalty, the DIA may consider evidence of the circumstances surrounding the violation. This includes, but is not limited to, the following factors:

- The number of assessments willingly and knowingly falsified.
- The history of the person who falsifies an assessment or causes an assessment to be falsified.
- The areas of assessment falsified.
- The areas of assessment falsified or caused to be falsified and the potential for harm to the resident.
- The relationship of the falsification of assessment to falsification of other records at the time of the visit.

Notice of a fine imposed for falsification of assessments or causing another person to falsify an assessment will be served upon the person personally or by certified mail.

Notice of intent to formally contest the fine must be given to DIA in writing. The notice must be postmarked within 20 working days after receipt of the notification of the fine.

An administrative hearing will be conducted pursuant to state law and DIA rules. A person who has exhausted all administrative remedies and is aggrieved by the final action of the DIA may petition for judicial review.

F. Requirement of Independent Assessors

If the Department of Inspections and Appeals (DIA) determines that there has been a knowing and willful certification of false assessments, or the causation of knowing and willful false assessments, the DIA may require that resident assessments be conducted and certified by persons independent of the facility who are approved by the state.

Criteria used to determine the need for independent assessors include:

- The involvement of facility management in the falsification of or causing resident assessments to be falsified.
- The facility's response to the falsification of or causing resident assessments to be falsified.
- The method used to prepare facility staff to do resident assessments.
- The number of persons involved in the falsification.
- The number of falsified resident assessments.
- The extent of harm to residents caused by the falsifications.

The DIA will specify the length of time that these independent assessments will be conducted and when they will begin. This determination is based on the extent of assessments and reassessments needed and the plan submitted by the facility to ensure falsifications will not occur in the future.

Written notice of the requirement to obtain independent assessments will be sent to the facility by certified mail or personal services. The notice will include:

- The date independent assessors are to begin assessments.
- Information on how independent assessors are to be approved.
- The anticipated length of time independent assessors will be needed.

The persons or agency chosen by the facility to conduct the independent assessments must be approved by the DIA before conducting any assessments. The approval will be based on the ability of the person or agency to conduct resident assessments in accordance with the applicable rules. Any costs incurred will be the responsibility of the facility.

Independent assessors must be used until all residents assessed by the disciplines involved have been reassessed by the independent assessor. The facility must submit a plan to the DIA for completing its own assessments. The DIA will evaluate the facility's proposal for ensuring assessments will not be falsified in the future.

A written request to appeal the requirement for independent assessors must be postmarked or personally served to the DIA within five working days after receipt of the notice requiring independent assessors.

A request to appeal stays the effective date of the requirement for independent assessments pending a final agency decision. An evidentiary hearing will be held pursuant to DIA rules no later than l5 working days after receipt of the appeal.

The written decision will be rendered no later than ten working days after the hearing. The decision rendered is a proposed decision which may be appealed to the director of the DIA. Final agency action may be appealed to the courts.

G. Sanctions for Failure to Meet Participation Requirements

If the Department of Inspections and Appeals (DIA) finds that a facility does not meet a requirement for participation in the program, it may impose one or more of the following remedies:

- Directed plan of correction. (Category 1)
- Directed in-service training. (Category 1)
- State monitoring of facility operations. (Category 1)
- Denial of Medicaid payment for all new admissions. (Category 2)
- Assessment of a civil money penalty of $50 to $3000 per day. (Category 2)
- Appointment of temporary management. (Category 3)
- Termination of the facility's participation in the Medicaid program. (Category 3)
- Assessment of civil money penalties of $3050 to $10,000 per day. (Category 3)

In an emergency situation, the DIA may transfer residents and close the facility.

To select the appropriate remedy to apply to a facility with deficiencies, the DIA determines the seriousness of the deficiencies by considering:

- Whether a facility's deficiencies constitute:
  - No actual harm, with a potential for minimal harm.
  - No actual harm, with a potential for more than minimal harm but not immediate jeopardy.
  - Actual harm that is not immediate jeopardy.
  - Immediate jeopardy to resident health or safety.
- Whether the deficiencies:
  - Are isolated.
  - Constitute a pattern.
  - Are widespread.
- The relationship of the one deficiency to other deficiencies resulting in noncompliance.
- The facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

The DIA will apply one or more of the remedies in Category 1 when:

- There are isolated deficiencies that constitute no actual harm, with a potential for more than minimal harm but not immediate jeopardy; or
- There is a pattern of deficiencies that constitutes no actual harm, with a potential for more than minimal harm but not immediate jeopardy.

The DIA will apply one or more of the remedies in Category 2 when:

- There are widespread deficiencies that constitute no actual harm, with a potential for more than minimal harm but not immediate jeopardy; or
- There are one or more deficiencies that constitute actual harm that is not immediate jeopardy.

Except when the facility is in substantial compliance, the DIA may apply one or more of the remedies in Category 1 or Category 2 to any deficiency.

The DIA will apply one or more of the remedies in Category 3 when there are one or more deficiencies that constitute immediate jeopardy to resident health and safety. When there are widespread deficiencies that constitute actual harm that is not immediate jeopardy, the DIA may impose temporary management in addition to Category 2 remedies.

The facility must submit a plan of correction for deficiencies unless there are only isolated deficiencies that constitute no actual harm and have potential for minimum harm only. The DIA must approve the facility's plan regardless of which remedies are applied.

If a facility fails to come into compliance with any requirement within three months after it is found out of compliance with that requirement, payment will be denied for any person admitted to the facility after three months.

If the DIA finds on three consecutive standard surveys that a facility has provided substandard quality of care:

- Payment will be denied for all new admissions..
- Regular on-site monitoring of the facility's compliance with the program requirements. The monitoring will continue until the facility has established that it is in and will remain in compliance.

The following sections give more information on:

- The meaning of the terms "substandard care" and "immediate jeopardy."
- Imposition of temporary management.
- Denial of payment for new Medicaid admissions.
- Imposition of state monitoring
- Termination of facility participation in the Medicaid program.

1. Definitions of Substandard Care and Immediate Jeopardy

For purposes of any sanction to be imposed, "substandard care" means one or more deficiencies related to the participation requirements for resident behavior and facility practices, quality of life, or quality of care which constitute either:

- Immediate jeopardy to resident health or safety;
- A pattern of or widespread actual harm that is not immediate jeopardy; or
- A widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

"Immediate jeopardy" means a situation in which immediate corrective action is necessary because the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. This includes, but is not limited to, the following:

- Situations or practices that constitute a serious fire hazard or emergency situation, such as:
  - Inadequate or faulty emergency power and lighting.
  - Electrical wiring that presents an immediate fire hazard.
  - Blocked or obstructed stairways, hallways and exits which prevent egress in the event of an emergency.
  - Widespread failure to enforce smoking restrictions.
  - Failure to maintain required fire protection systems in an operating condition.
  - Failure to maintain the integrity of fire and smoke barriers, such as removal of stairway doors and major unprotected openings in corridor walls.

- Widespread insect or rodent infestation indicative of food contamination or the possible spread of contagion.
- Failure to use adequate infection control procedures.
- Widespread patterns of resident abuse or poor resident care, including:
  - Instances of malnutrition or dehydration that are unrelated to the resident's condition and are a result of poor resident care.
  - A pattern of negligence by staff with the result that residents are often left lying in urine, feces or other waste.
  - Use of physical or chemical restraints in excess of that which is ordered by a physician.
- Drug or pharmaceutical hazards that directly affect resident health and safety, such as:
  - Widespread drug errors, mishandling of drugs or other resident related pharmacy problems.
  - Failure to provide medications as prescribed.
  - Failure to monitor drugs as evidenced by lack of ordered laboratory work, failure to take vital signs as indicated by drug regimen, and lack of other nursing monitoring practices.
- Gross mishandling of drugs, such as leaving drug trays unattended and available to residents and visitors.
- Administration of drugs by unqualified staff.
- Administration of experimental drugs without the informed consent of the resident or responsible party.
- Inadequate procedures for procurement, safekeeping, and transfusion of blood and blood products that could jeopardize resident health and safety.
- Excessive hot or cold temperatures in resident care areas of the facility to the extent that residents are experiencing signs of hyperthermia or hypothermia, when the nursing facility does not have a short-term and effective plan for ameliorating these temperatures.

2. State Monitoring

The Department of Inspections and Appeals (DIA) will designate a DIA employee or contractor as a monitor for any facility which has been found on three consecutive standard surveys to have provided substandard quality of care. Monitors will be continue until the facility has demonstrated that it is in compliance and will remain in compliance with the law.

DIA may also designate monitors in:

- Facilities that have failed to come into compliance with any requirement within three months after they are found to be out of compliance.
- A facility that has corrected deficiencies, but verification of continued compliance is needed.
- Any facility when the state has reason to question that facility's compliance.

Monitors must be persons who have knowledge related to the deficiencies cited. Monitors must not have any financial interest in the facility or any affiliate and must not be related to the licensee, the manager, or any employee of the facility.

The DIA will inform the facility of the appointment of a monitor before the date monitoring begins. When the DIA designates a monitor, the DIA will develop a monitoring plan that is related to the type of deficiencies. The plan will:

- Include who is designated as the monitor.
- Include the frequency and duration of visits by the monitor, as well as a schedule of written reports. A copy of these reports will be sent to the facility.
- Be reviewed weekly by the DIA or at the recommendation of the monitor.
- Have a designated time frame for correction of deficiencies.

The monitor oversees the correction of deficiencies at the facility site and protects the facility's residents from harm. Monitors are responsible for observing the facility's operations and efforts to come into compliance. The monitor must have access to the facility 24 hours a day, seven days a week. Monitors will report the results of those observations to the DIA.

If the monitor reports little or no progress on the part of the facility in correcting the deficiencies within the designated time, the DIA may take alternative or additional action.

3. Denial of Payment for New Admissions

The Department of Human Services will deny payment for newly admitted Medicaid residents when:

- The facility has failed to correct deficiencies within 90 days after the survey identifying noncompliance.
- The Department of Inspections and Appeals (DIA) has cited the facility with substandard care on the last three consecutive standard surveys.

A deficiency statement issued by the DIA will include information that failure to correct deficiencies within three months will result in denial of payment for new admissions. The time period for correction begins three days after the deficiency statement is mailed.

The Department of Human Services may also deny payment for new Medicaid admissions in the case of physical plan emergencies or insufficient staff.

"New admission" means the admission into a facility of a Medicaid resident who has never been in the facility or, if previously admitted, has been discharged or has voluntarily left the facility. The term does not include the following:

- Persons who were in the facility before the effective date of the sanction, but who were discharged on or after that date.
- Persons who were in the facility before the effective date of the sanction but became eligible for Medicaid on or after the date.
- Persons who were in the facility before the effective date of the sanction but who left the facility for a temporary absence, regardless of whether their departure occurred before or after the effective date of the sanction. Upon their return they are not considered new admissions.

When the DIA finds that the facility has failed to correct a deficiency, the Department of Human Services will send a notice by certified mail effective the tenth working day after receipt. This notice will include the justification for imposing the denial of payment for new Medicaid residents admitted to the facility and the facility's right to appeal.

The facility may appeal the decision to deny payment for new admissions of Medicaid residents in writing to the DIA within ten working days after receipt of the notice. The appeal does not stay the denial of payment.

The administrative hearing will be held and the decision rendered within 30 days after the DIA receives the request for a hearing.

When the Department has denied payment for new admissions, it will notify all transferring facilities, referral agencies, and persons contacting the nursing facility regarding an admission. At a minimum, the Department will notify:

- The Department's county office.
- The Iowa Foundation for Medical Care.
- Local hospital social workers.
- The long-term care ombudsman.
- The facility's resident advocate committee.
- The Department of Elder Affairs.
- Referral agencies for persons with mental retardation or mental illness.

The notice will also be posted in the facility. Anyone calling the facility regarding an admission must be notified the facility has been denied payment for new Medicaid admissions.

4. Temporary Management

The Department of Inspections and Appeals (DIA) may appoint a temporary manager when there is immediate jeopardy to resident health or safety or when there are widespread deficiencies that cause actual harm.

The person appointed to serve as a temporary manager must:

- Be qualified to oversee correction of deficiencies on the basis of experience and education, as determined by the DIA.
- Not have been found guilty of misconduct by any licensing board or professional society in any state.
- Have no financial ownership interest in the facility, nor have an immediate family member with ownership in the facility.
- Not currently serve as a member of the staff of the facility nor have served within the past two years.

The temporary manager has the authority to oversee the operation of the facility and to ensure the health and safety of the facility's residents. The temporary manager must:

- Make at least monthly reports to the court and the DIA regarding progress made by the facility in making corrections of the deficiencies.
- Spend sufficient time in the facility to mitigate the circumstances which resulted in the appointment of the temporary manager.
- Develop a written plan for correcting the deficiencies which were the basis for appointing a temporary manager.

The facility is responsible for paying the salary of the temporary manager. The salary shall be at least equivalent to the sum of the following*:*

- The prevailing salary paid by providers for positions of this type in the facility's geographic area.
- Additional costs that the provider reasonably have incurred by the person had been in an employment relationship.
- Any other transportation and lodging costs incurred by the person in furnishing services under the arrangement, up to the maximum per diem for state employees.

If the facility fails to relinquish authority to the temporary manager, the facility's Medicaid provider agreement will be terminated. This includes failure to pay the temporary manager's salary.

The temporary management will not be terminated until the DIA has determined that the facility has the management capacity to ensure continued compliance with all requirements of the program.

The licensee must send a written request to terminate the temporary manager to the DIA, the temporary manager, and any other parties to the action. The request must include:

- A statement of any changes the licensee proposes to make in the operation or management to ensure continued compliance with requirements.
- The reasons why the licensee believes it has management capacity to ensure continued compliance.

5. Termination of Medicaid Certification

If a facility's participation is terminated under Medicare, the Department of Human Services will take steps to terminate the facility's participation under Medicaid.

When decertification is contemplated as a result of survey findings, the Department of Inspections and Appeals (DIA) sends a notice to the facility which:

- Advises the facility of its rights to due process and the expected schedule for termination action.
- States that the deficiency must be corrected and the correction verified by the DIA to suspend the termination.

When the DIA finds upon survey that a facility is not in compliance with one or more conditions of participation or coverage, and the cited deficiencies limit the capacity of the facility to furnish adequate level or quality of care, termination procedures must be completed within 90 days.

No later than l5 days following the survey date, the DIA will notify the facility in writing of cited deficiencies and of recommended termination from the Medicaid program, to be effective within 90 days from the date of the survey.

When the facility has made a credible allegation of compliance, DIA will conduct a revisit to determine whether compliance or acceptable progress has been achieved. DIA may conduct a second visit between the forty-sixth and ninetieth days.

No later than the seventieth day after the date of survey, the Health Care Financing Administration will send an official termination notice to the facility. Termination will take effect on the ninetieth day following the survey date, if compliance has not been achieved.

When the DIA finds upon survey that a facility poses an immediate and serious threat to patients, termination procedures will be completed within 23 calendar days.

No later than two working days following the survey date, DIA will notify the facility by telegram or overnight express of the facility's deficiencies and termination from the Medicaid program.

No later than the fifth working day following the survey date, the Health Care Financing Administration will notify the facility by of the proposed termination action.

The termination will take effect no later than the twenty-third calendar day following the date of the survey, unless compliance has been met or the threat has been removed. The facility may appeal the decision in accordance with Department procedures.

When the threat has been removed, but deficiencies exist, the DIA may grant the facility up to 67 more days to correct the deficiencies, or 90 days total.

If the Department cancels or denies further Medicaid participation due to a survey, federal financial participation may continue for 30 days beyond the date if an extension is necessary to ensure the orderly transfer of residents.

H. Appeals

Any actions of the of the Department of Human Services which nursing facilities believe are unwarranted or unjust may be appealed to the Director of the Department. This appeal process should be used only after exhausting normal administrative processes.

Any person or facility wishing to appeal a Departmental action or decision must do so within 30 days of notification of the action or decision. Appeals should be directed to the office taking the action.

Facilities may obtain information concerning appeals by contacting the Appeals Section of the Division of Policy Coordination, Department of Human Services, Hoover State Office Building, Des Moines, Iowa 50319-0114.

When the Department of Human Services takes decertification action for reasons unrelated to the survey report, the appeal is filed with the Department of Human Services. The hearing is held by the Department of Inspections and Appeals, but the final decision is issued by the Department of Human Services.

I. BILLING PROCEDURES

Nursing facility claims for payment are processed by the Department's fiscal agent, Consultec. Facilities can submit claims either on paper or electronically.

Consultec provides software for electronic claims submission at no charge. To request this software, referred to as ASAP, contact the EDI Coordinator at Consultec Inc., PO Box 14422, Des Moines, IA 50306-3422. You will receive ASAP diskettes and an instruction manual that explains how to install the software. Consultec also has field representatives available upon request to assist with any questions or problems.

Facilities that do not submit claims electronically are sent form 470-0039, *Iowa Medicaid Long Term Care Claim*, at the end of each month. The form lists information on Medicaid recipients at the facility according to Department records.

A. Time Frames for Submitting Claims

Claims can be submitted any time during the month for the previous month. However, for residents who are in the facility all month, submit only one claim per month after the end of the month.

Payment will be made for covered services when the fiscal agent receives the initial claim within one year from the date of services. Claims submitted beyond the one-year limit may be paid only when they are delayed due to delays in receiving third-party payments or retroactive eligibility determinations.

The fiscal agent generates payments weekly, and mails checks every Wednesday. Electronic funds transfers are made each Wednesday evening.

B. Instructions for *Iowa Medicaid Long Term Care Claim*, 470-0039

The fiscal agent issues form 470-0039, *Iowa Medicaid Long Term Care Claim*, monthly to facilities that do not bill electronically. This form is also referred to as a "TAD" or Turnaround Document.

The fields on the TAD are completed for each resident according to fiscal agent and Medicaid eligibility records. Review the form carefully. Mark any changes or correction in red ink.

Note any residents who had covered or noncovered leave days or who were discharged during the billing month in red in the appropriate fields on the TAD. (No changes are necessary if the client did not have leave days and was not discharged during the month.)

If you need to resubmit a claim, you must use a blank TAD and complete all of the appropriate fields. Blank TADs are provided at the end of each monthly TAD. Note on the form that it is a resubmission of a previous claim.

Each page of the form must be signed and dated by the facility's authorized representative. For resubmitted claims, use the original signature date. Keep one copy and return the other copy to the fiscal agent.

1. **Medicaid I.D.#** Enter the resident's I.D. number assigned by the Department. This number consists of seven numbers followed by a letter. Obtain this number from form MA-2139, *Facility Card*, or the resident's *Medical Assistance Eligibility Card*.

2. **Name** Enter the resident's last name and first name.

3. **L.O.C. (Level Of Care)** Leave blank if the resident is at ICF or ICF/MR level of care. Enter an "R" if the resident is RCF.

4. **Termination** Enter the applicable discharge code:

   A Moved to the hospital
   B Moved to a skilled nursing facility
   C Moved to another nursing facility
   D Moved to an ICF/MR
   E Moved to an RCF
   F Moved home with self care
   G Moved home with rehabilitation service
   H Moved home with home health
   I Moved to other institution
   J Deceased

5. **Patient Acct#** Enter the resident's account number if you assign one.

6. **Medicare Coverage** Leave blank.

7. **Facility Admit Date** Enter the date the resident was admitted to the facility if the admission was during the month being claimed.

8. **Facility Disc Date** If the resident was in the facility the entire month, leave this field blank. If the resident was discharged from the facility during the month, enter the last date service was provided. The entry should show month, day, and year, in a six-digit number.

9. **First D.O.S.** (Date of Service) Enter the first date of the month for which payment is being claimed (month, day, and year, in a six-digit number).

10. **Last D.O.S.** (Date of Service) Enter the last date of the month for which payment is being claimed (month, day, and year, in a six-digit number).

11. **Unlabeled Field** Leave this field blank.

12. **Per Diem Rate** Enter the facility's computed daily rate. This rate may not be the same as the facility's Medicaid rate if the facility's computed rate is above the Medicaid reimbursement cap. When the fiscal agent processes the claim, the cap will be applied, and the facility will receive the computed rate or the cap rate, whichever is lower.

13. # **Days** Enter the number of days for the month being claimed from the first day of the month to the last day of the month.

14. **Amount** Enter the total amount being claimed as determined by multiplying the per diem (field 12) by the number of days (field 13). When the claim is processed, the facility will be reimbursed based on the facility's computed rate or the cap rate, whichever is lower.

15. Leave Days/Visit Enter the number of covered reserve bed days for a resident who was out of the facility for therapeutic leave or home visit. A covered reserve bed day is one that can be paid by Medicaid. Medicaid will pay up to 18 days in any calendar year to hold the bed during visits. See Chapter E, Section VII.F, **Periods of Service for Which Payment Is Authorized**.

16. Leave Days/Hosp Enter the number of covered reserve bed days for a resident who was out of the facility for a hospital stay. A covered reserve bed day is one that can be paid by Medicaid. Medicaid will pay up to 10 days in any calendar month to hold the bed during a hospital stay.

17. Leave Days/Non-Cov. Enter the number of days that the resident was out of the facility that exceed the reserve bed maximum. These are days that are not reimbursable through the Medicaid program.

18. 3rd Party Source If the resident is covered by other insurance, enter the name of the insurance company.

19. 3rd Party Amount Enter the amount paid by the insurance towards this claim. Do not enter client participation in this field.

20. 3rd Party Source If the resident is covered by other insurance, enter the name of the insurance company.

21. 3rd Party Amount Enter the amount paid by the insurance towards this claim. Do not enter client participation in this field.

22. Net Amount Enter the net charge amount, which is the amount claimed (field 14) minus third-party payments (fields 19 and 21).

C. Facsimile Claim Form 470-0039

A facsimile of form 470-0039, *Iowa Medicaid Long Term Care Claim* (TAD) follows.

II. REMITTANCE ADVICE

You will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. The categories are:

- PAID, indicating all processed claims, credits, and adjustments for which there is full or partial reimbursement.
- DENIED, representing all processed claims for which no reimbursement is made.
- SUSPENDED, reflecting claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which of these options you have specified:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims, with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit - the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

When it is necessary to contact the fiscal agent with questions, keep the *Remittance Advice* handy. Refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

A. Facsimile of *Remittance Advice*

B. *Remittance Advice* Field Description

A detailed field-by-field description of each information line follows:

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2. *Remittance Advice* number.
3. Date claim paid.
4. Billing provider's Medicaid (Title XIX) number.
5. *Remittance Advice* page number.
6. Type of claim used to bill Medicaid.
7. Status of following claims:
   - **Paid** - claims for which reimbursement is being made.
   - **Denied** - claims for which no reimbursement is being made.
   - **Suspended** - claims in process. These claims have not yet been paid or denied.
8. Recipients' last and first names.
9. Recipients' Medicaid (Title XIX) numbers.
10. Transaction control numbers assigned to each claim by the fiscal agent. Please use this number when making claim inquiries.
11. Coverage dates as they appear on the claim.
12. Total number of covered days.

13. Total number of hospital days, noncovered days and visit days as reported by the provider.

14. Total charges submitted by the provider for each claim.

15. Total amount applied to this claim from other resources, i.e., client participation, other insurance, or spenddown.

16. Total amount of Medicaid reimbursement as allowed for this claim.

17. Explanation of benefits (EOB) code as it applies to entire claim. This code is for informational purposes or to explain why a claim was denied. Refer to the end of the *Remittance Advice* for EOB code explanations.

18. Remittance totals (found at the end of the *Remittance Advice*):

    - Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid.
    - Number of paid adjusted claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid.
    - Number of denied original claims and the amount billed by the provider.
    - Number of denied adjusted claims and the amount billed by the provider.
    - Number of pended claims (in process) and the amount billed by the provider.
    - Amount of the check.

19. Description of individual explanation of benefit codes, if necessary. Each EOB code is following by important information and advice.

III. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice,* and any supporting documentation you want to have considered, such as additional medical records. Send these to:

Consultec, Attn: Provider Inquiry
PO Box 14422
Des Moines, Iowa 50306-3422

To make an adjustment to a claim following receipt of the *Remittance Advice,* use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- A paid claim amount needs to be changed, or
- Money needs to be credited back, or
- An entire *remittance advice* should be canceled.

Send this form to:

Consultec, Attn: Credits and Adjustments
PO Box 14422
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

A. Facsimile of Provider Inquiry, 470-3744

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Iowa Medicaid Program

PROVIDER INQUIRY

Attach supporting documentation. Check applicable boxes: ❒ Claim copy ❒ Remittance copy
❑ Other pertinent information for possible claim reprocessing.

INQUIRY A

1. 17-DIGIT TCN

2. NATURE OF INQUIRY

(Please do not write below this line)
FOR CONSULTEC RESPONSE

INQUIRY B

1. 17–DIGIT TCN

2. NATURE OF INQUIRY

(Please do not write below this line)
FOR CONSULTEC RESPONSE

Provider Signature/Date:	**MAIL TO: CONSULTEC P. O. BOX 14422 DES MOINES IA 50306-3422**	**Consultec Signature/Date:**

Provider Please Complete:

7-digit Medicaid Provider ID#_____

Telephone_____

Name
Street
City, St
Zip

(FOR CONSULTEC USE ONLY)

PR Inquiry Log #_____

Received Date Stamp:

Page 14 was intentionally left blank.

Iowa Medicaid Program

CREDIT/ADJUSTMENT REQUEST

Do **not** use this form if your claim was denied. Resubmit denied claims.

SECTION A: Check the most appropriate action and complete steps for that request.

❑ CLAIM ADJUSTMENT	❑ CLAIM CREDIT	❑ CANCELLATION OF ENTIRE REMITTANCE ADVICE
♦ Attach a complete copy of claim. (If electronic, use next step.) ♦ Attach a copy of the Remittance Advice with corrections in **red ink**. ♦ Complete Sections B and C.	♦ Attach a copy of the Remittance Advice. ♦ Complete Sections B and C.	♦ Use only if all claims on Remittance Advice are incorrect. This option is rarely used. ♦ Attach the check and Remittance Advice. ♦ Skip Section B. Complete Section C.

SECTION B:

1. 17-digit TCN																	

2. Pay-to Provider #:	**4. 8-character Iowa Medicaid Recipient ID: (e.g., 1234567A)**

3. Provider Name and Address:

5. Reason for Adjustment or Credit Request:

SECTION C:	**Provider/Representative Signature:**
	Date:

CONSULTEC USE ONLY: REMARKS/STATUS

Return All Requests To:

Consultec
PO Box 14422
Des Moines, IA 50306-3422

For Human Services use only:

General Letter No. 8-AP-110
Employees' Manual, Title 8
Medicaid Appendix

Iowa Department of Human Services

April 16, 1999

NURSING FACILITY MANUAL TRANSMITTAL NO. 99-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Nursing Facility Manual***, Title Page, new; Table of Contents (pages 4 through 8), new; Chapter E, *Coverage and Limitations*, pages 1 through 220, new; and Chapter F, *Billing and Payment*, pages 1 through 13, new.

The ***Nursing Facility*** (NF) provider manual format has been changed. The manual is revised with a goal to have consistency with all Medicaid provider manuals. Chapters A, B, C, and D are common to all provider manuals. Chapter E and F are specific to the nursing facility providers.

The following changes were made from the previous nursing facility provider manual:

- Forms 470-0254, *Institutional Medicaid Provider Application*, and HCFA-2567B, *Post Certification Revisit Report*, are removed.
- The nurse aide training section is updated to reflect the current process. The NATCEP waiver process and form request are added.
- The automated Minimum Data Set process and version 2.0 of the form are added.
- The PASARR Level I and II process is updated. Billing for Level II evaluations was removed, since this is part of the mental health provider manuals.
- Instructions on the inactive review status for IFMC review are revised.
- The Medicaid *Financial and Statistical Report* should be sent to the Department's accounting firm, Ryun, Givens, Wenthe, Inc., at 1601 48th Street, Suite 150, West Des Moines IA 50266-6756.
- The instructions for the *Financial and Statistical Report* are revised to update the nonlegend drugs authorized for direct Medicaid payment and to clarify the transportation policy.
- The Department's fiscal agent is revised to reflect Consultec.
- The billing information is contained in Chapter F.
- Other changes were related typographical or grammatical errors.

Date Effective

February 1, 1999

Material Superseded

This manual replaces the *Medicaid Provider Manual for Nursing Facilities*, issued as Comm. 45. Destroy those manuals.

Additional Information

With this change in format, the nursing facility manuals will be maintained by Consultec. The Division of Medical Services will no longer maintain stocks of this manual. Submit orders for manuals to Consultec Provider Relations.

Direct questions about this manual as follows:

- Questions related to payment policy, claim payments, and unpaid bills to Consultec.
- Questions related to survey and certification to Department of Inspections and Appeals, Division of Health Facilities.
- Questions related to Medicaid nursing facility policy to Department of Human Services, Division of Medical Services.

For Human Services use only:

General Letter No. 8-AP-121
Employees' Manual, Title 8
Medicaid Appendix

Iowa Department of Human Services

July 9, 1999

NURSING FACILITY MANUAL TRANSMITTAL NO. 99-2

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Nursing Facility Manual***, Table of Contents (pages 6 and 7), revised; Chapter E, *Coverage and Limitations*, pages 126, 133, 152, 154 through 168, 203, and 216, revised; and page 168a, new.

This letter provides information about:

- Changes made to the cost reporting requirements for nursing facilities through legislative action by the 1999 Iowa General Assembly.
- Name change of the care review committee.

Cost Reports

Effective July 1, 1999, all nursing facilities participating in the Medicaid program must submit form 470-0030, *Financial and Statistical Report*. Before this, facilities with all beds certified by Medicare that participated in the Medicaid skilled program were exempt.

Facilities that do not have a current cost report on file with the Department as of June 30, 1999, will continue to receive the per diem rate in effect for that facility on June 30, 1999, until the facility's costs are above that rate or until June 30, 2000, whichever is earlier. These facilities must submit semiannual cost reports beginning July 1, 1999, or after, based on the closing date of the facility's fiscal year.

Effective January 1, 2000, the Department will adjust the maximum nursing facility reimbursement rate to the 70^{th} percentile, as calculated from the December 31, 1999, cost and statistical data reports. The maximim will be increased to the extent that funds are available within the nursing facility and Medicaid appropriations as a whole for the fiscal year beginning July 1, 1999.

This adjustment will be effective only for nursing facilities that provide additional written documentation in a cost report which demonstrates increased expenditures for direct care in the form of wages during a cost reporting period in that fiscal year. This documentation will be obtained through Schedules C and H of the nursing facility cost reports.

In order to be eligible for the increased reimbursement, a nursing facility must submit the cost report with the additional documentation by June 30, 2000.

Additional Information for Cost Reports

The 1999 Iowa General Assembly expanded the requirements for the nursing facility cost reports. Beginning July 1, 1999, all facilities must include:

- The number of hours of care provided per resident per day and
- The starting and average wage for the specific cost reporting period.

Schedule H is added to the *Financial and Statistical Report* to collect this information for cost reporting periods beginning July 1, 1999. (See page 168a for a facsimile.)

Additionally the Iowa General Assembly is requiring baseline information to be collected from all facilities. Please complete Schedule H as it pertains to your facility as of July 1,1999. Send this baseline information to Ryun, Givens, Wenthe, Inc. by September 1, 1999.

Other

An error was corrected in the last sentence of page E-126, pertaining to hospital reserve bed days.

On page E-216, the Care Review Committee's name was changed to the Resident Advocate Committee.

Date Effective

July 1, 1999

Material Superseded

Remove the following pages from ***Nursing Facility Manual*** and destroy them.

Page	Date
Table of Contents (page 6 and 7)	February 1, 1999
Chapter E	
126, 133, 152, 154-168, 203, 216	February 1, 1999

Additional Information

Photocopy or recreate Schedule H from the sample in this manual. You may use up supplies of the previous version of the *Financial and Statistical Report* if you attach the new schedule.

If any portion of the letter is not clear, please direct your inquiries to Ryun, Givens, Wenthe, & Co. at (515) 225-3141.

For Human Services use only:

General Letter No. 8-AP-128
Employees' Manual, Title 8
Medicaid Appendix

Iowa Department of Human Services

October 26, 1999

NURSING FACILITY MANUAL TRANSMITTAL NO. 99-3

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Nursing Facility Manual***, Chapter E, *Coverage and Limitations*, page 125, revised.

This letter provides information about changes in the Iowa Administrative Code for nursing facilities.

Page 125 was revised, to reflect a change in Medicaid policy to require a nursing facility accept Medicaid payment as payment in full effective with a resident's beginning date of eligibility. It further provides that the facility must refund any payment received from the resident or family member for the period of time for which the resident was determined to be eligible.

Comm. 52, *Medicaid for People in Nursing Homes and Other Care Facilities*, is also being revised to reflect this change. A copy of the revised booklet will be mailed to each facility when it is printed. Additional copies will be available for order from the Iowa State Industries. Supplies of the previous version of the booklet should be discarded when the revised version becomes available.

Date Effective

November 1, 1999

Material Superseded

Remove page 125, dated February 1, 1999, from Chapter E of the ***Nursing Facility Manual*** and destroy it.

Additional Information

Direct questions about this change as follows:

- Questions related to Medicaid nursing facility policy to Department of Human Services, Division of Medical Services.
- Questions related to a specific resident's eligibility to the county Department of Human Service office.

For Human Services use only:

General Letter No. 8-AP-147
Employees' Manual, Title 8
Medicaid Appendix

Iowa Department of Human Services

June 26, 2000

NURSING FACILITY MANUAL TRANSMITTAL NO. 00-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Nursing Facility Manual***, Table of Contents (page 8), revised; Chapter E, *Coverage and Limitations*, pages 64, 135, 136, 139, 154 through 168, 168a, 178, 193, and 194, revised; pages 64a, 136a, 178a, and 194a, new; Chapter F, *Billing and Payment*, pages 12 and 13, revised; and page 15, new.

This letter provides information about changes made for nursing facilities through legislative action by the 2000 Iowa General Assembly.

- **Transitional Case Mix Factor.** A semiannual case mix factor will be added to the facility's payment rate for those facilities which exceed the Iowa nursing facility case mix average.
- **Occupancy Factor.** The occupancy factor was modified to exclude patient care service expenses.
- **Cost Reports.** An itemization of home or principal office or headquarters of the nursing facility is required within the administrative cost line item. Additional reporting is now required for facilities that receive essential services from a home office or company headquarters.

  Schedule A of the *Financial and Statistical Report* is also modified for reporting of the computed average private-pay rate. The information for the private-pay rate computation has not changed. (See Chapter E, page 139.)
- **Resident Assessment.** A facility provider must conduct a resident assessment of all people seeking nursing facility placement before admission. The purpose of this assessment is to identify those people who may be able to be served by home- and community-based services, and provide education, assistance, or referral for these services.

Date Effective

July 1, 2000

Material Superseded

Remove the following pages from ***Nursing Facility Manual*** and destroy them:

Page	Date
Table of Contents (page 8)	February 1, 1999
Chapter E	
64, 135, 136, 139	February 1, 1999
154-168, 168a	6/99

178, 193, 194	February 1, 1999
Chapter F	
12	February 1, 1999
13	7/97

Additional Information

Photocopy or recreate the *Financial and Statistical Report* from the sample in this manual. You may use up supplies of the previous version of the cost report if you attach the additional information. If any portion of the letter is not clear, please direct your inquiries to Ryun, Givens, Wenthe, & Co. at (515) 225-3141.

Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-154
Employees' Manual, Title 8
Medicaid Appendix

November 1, 2000

NURSING FACILITY MANUAL TRANSMITTAL NO. 00-2

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***NURSING FACILITY MANUAL***, Chapter E, *Coverage and Limitations*, pages 67 through 82, 119, 120, and 151, revised.

This letter provides updated versions of:

- *Minimum Data Set* (MDS) – Version 2.0 forms
- *Case Activity Report*, form 470-0042
- *Adjustment to Facility Payment*, form 470-0041

The Health Care Financing Administration has updated the resident assessment instrument used for assessment of residents in certified skilled nursing and nursing facilities.

The *Minimum Data Set* (MDS) Version 2.0 forms have been revised to accommodate the new MDS correction policy and federal requirements at 42 CFR 483.20(h)(i)(1) and (2). These changes require individual staff members completing any portion of the resident assessment instrument to sign and certify the accuracy of the portions they completed.

The Iowa Department of Inspections and Appeals, Health Facilities Division, sent instructions for the forms to each nursing facility in August 2000. The Department of Inspections and Appeals requires the implementation of the September 2000 MDS forms as follows:

- Background (face sheet) with a completion date on or after September 1, 2000.
- Full assessments (and basic assessment tracking form) with an assessment reference date (MDS item A3a) on or after September 1, 2000.
- Two-page quarterly assessments (and basic assessment tracking form) with an assessment reference date (MDS item A3a) on or after September 1, 2000.
- Discharge tracking forms with a discharge date on or after September 1, 2000.
- Reentry tracking forms with a reentry date on or after September 1, 2000.
- Correction request form with an attestation date on or after September 1, 2000.

Date Effective

September 1, 2000

Material Superseded

Remove the following pages from ***NURSING FACILITY MANUAL*** and destroy them:

Page	Date
Chapter E	
67-82	1/30/98
119, 120	6/97
151	7/97

Additional Information

As the state moves further towards implementation of a Medicaid case-mix reimbursement system, we are anticipating that the three-page MDS Quarterly Assessment Form (Optional Version for RUG-III 1997 Update) and Section T will be required with assessments transmitted on or after January 1, 2001. These changes will accommodate a reimbursement system that will be responsive to changes in resident acuity.

Once approval is received from the Health Care Financing Administration, a mass mailing will be sent to all providers with detailed instructions and copies of the forms so you can begin notification to your software vendors. Information will also be published in the MDS Automation quarterly newsletter and the DIA Insight.

For questions on implementation of the September 2000 MDS form, contact Karen Zaabel, R.N. at 515-242-5991 or by email at kzaabel@dia.state.ia.us.